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**The Implementation of General Practitioner Maternity
Unit Closure Proposals in Hospitals**

by

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To: Professor Raymond Chausse

Ecole des Hautes Etudes
Commerciales de Montreal

"Implementation is worth studying precisely because it is a struggle over the realisation of ideas. It is the analytical equivalent of original sin; there is no escape from implementation and its attendant responsibilities. What has policy wrought? Having tasted of the fruit of the tree of knowledge, the implementer can only answer, and with conviction, it depends. ..."

Pressman, J. and Wildavsky, A. (1979) Implementation, 2nd edition, University of California Press, Berkeley, p. 194.

SUMMARY OF THE RESEARCH

This dissertation examines the 'implementation gap' and reports evidence on progress in implementing closure of health services at micro-implementation level. Specifically, the research develops an historically bound, processual and contextual account of the development and fate of permanent closures of General Practitioner Maternity Units (GPMU) in four neighbouring Oxford DHAs.

The major objectives of this study are to illustrate and analyse the process by which the 'implementation gap' is closed and to identify some of the potentially important factors which help to explain the pace and rate of change differential across health districts.

The key questions guiding the research include: What affects the pace of implementation? Why do districts fail or succeed in implementing change? What affects the 'implementability' of the GPMU closure proposals?

To make further progress towards an understanding of implementation, this research adopts a new, eclectic, and integrative approach: the Contextualist Approach. One major theme underlying most of the results and ideas presented here, is that the outcome of implementation can be explained by the interplay between the content, the context and the process of implementation itself.

The research is essentially qualitative. The data collection process comprises three main activities: documentary search, in-depth interviews, and ethnographic material. The strategy of data presentation and analysis was to develop a descriptive framework for organising the data (Yin, 1989).

A set of three interacting groups of factors is found to affect implementability and rate and pace of change at micro-implementation level - the nature of the locale, leadership, and the quality of the proposal itself.

Although other authors have studied health service policy, this research is unique in offering an extensive treatment of the changing policy context under investigation. It is also the first to investigate partial, as opposed to total, closure of hospitals within the context of the NHS, with particular emphasis on the GPMU.

ABBREVIATIONS

AGH	Amersham General Hospital
AHA	Area Health Authority
BCG	Boston Consulting Group
BCOG	British College of Obstetricians and Gynaecologists
BMA	British Medical Association
CAWS	Campaign Against Ward Shutting
CCSC	Centre for Corporate Strategy and Change
CHC	Community Health Council
CNO	Chief Nursing Officer
DA	District Administrator
DCP	District Community Physician
DEB	District Executive Board
DGH	District General Hospital
DGM	District General Manager
DHA	District Health Authority
DHSS	Department of Health and Social Security
DMB	District Management Board
DMO	District Medical Officer
DMT	District Management Team
DNO	District Nursing Officer
DT	District Treasurer
EMI	Elderly Mentally Infirm
ENT	Ear, Nose and Throat
GE	General Electric

GH	General Hospital
GP	General Practitioner
GPMU	General Practitioner Maternity Unit
IH	Isebrook Hospital
JTUC	Joint Trade Unions Committee
KGH	Kettering General Hospital
MBE	Member of the British Empire
MH	Mentally Handicapped
MI	Mentally Infirm
MKDC	Milton Keynes Development Corporation
MP	Member of Parliament
NCT	National Childbirth Trust
NETRHA	North East Thames Regional Health Authority
NHS	National Health Service
NHSTA	National Health Service Training Agency
OCD	Organisational Change and Development
OD	Organisational Development
ORHA	Oxford Regional Health Authority
OT	Operating Theatre
PI	Performance Indicator
PIMS	Profit Income Margin System
PMR	Perinatal Mortality Ratio
PPBS	Planning Programming and Budgeting System
PRU	Pain Relief Unit
RAWP	Resource Allocation Working Party

RBH	Regional Hospital Board
RCM	Royal College of Midwives
RCOG	Royal College of Obstetricians and Gynaecologists
RGM	Regional General Manager
RHA	Regional Health Authority
RPT	Regional Planning Team
RRU	Rheumatology/Rehabilitation Unit
RTO	Regional Team of Officers
SIC	Save Isebrook Campaign
SMG	Senior Management Group
SMH	Shrubbery Maternity Home
SMR	Standard Mortality Ratio
STH	Stone Maternity Home
UGM	Unit General Manager
UK	United Kingdom
USA	United States of America
WAG	Westbury Action Group
WDHA	Wycombe District Health Authority
WGH	Wycombe General Hospital
ZBB	Zero Base Budgeting

CHAPTER ONE

Introduction

This empirical research aims to study the gap which often exists in public hospitals between statements of intentions and their operational implementation. The question of closing the "implementation gap" (Dunshire, 1978) is one of the fundamental issues facing any large-scale organisation whether public or commercial. Closing the implementation gap is required not only because of the pressing need to improve the efficiency and effectiveness of public organisations, but also because of the necessity to re-build credibility in public sector management and confidence in the public manager.

This dissertation examines the implementation of permanent closure of General Practitioner Maternity Units (GPMUs) by four District Health Authorities (DHA) which form part of the Oxford Regional Health Authority (ORHA). The GPMUs studied in this research are: (1) the Amersham GPMU in the Wycombe health district; (2) the Abingdon GPMU in the Oxfordshire health district; (3) the Bletchley GPMU and Westbury Maternity Home in the new Milton Keynes health district; and (4) the Isebrook GPMU in the Kettering health district.

It is important to distinguish between GPMUs and consultant obstetric wards. The latter provide

specialist obstetric medical care for all women but particularly for those at higher risk. GPMUs provide General Practitioner's (GP) obstetric and midwifery care to women who have been selected during the antenatal period as being at low risk. These units have access to emergency cover from the local consultant obstetric ward.

Where GP units are either located within a hospital with a consultant obstetric department or adjacent to consultant maternity hospitals, they are designated as "integrated" GP units. Where they are not within a hospital with a consultant department, they are usually referred to, particularly by the proponents of their closure, as "isolated" GPMUs because they have no resident medical officers and limited anaesthetic facilities. In the Oxford health region, and for the purpose of this research, these units are generally called "peripheral" GPMUs because of their location in small hospitals at some distance from the central DGHs (District General Hospital).

The process of implementation in the public sector can be studied at two different levels: (1) the macro-implementation level, and (2) the micro-implementation level (Berman, 1978; Scheirer, 1981).

"The central government must execute its policy so as to influence local delivery organisations to behave in desired ways; we call this the macro-implementation problem.

In response to central actions, the local organisations have to devise and carry out their own internal policies; we call this the micro-implementation problem." (Berman, 1978, p.164)

In the UK, Dunshire (1978), Barrett & Fudge (1981), Levis & Wallace (1984), and Hogwood & Gunn (1986) have led the theoretical, conceptual, and empirical development in the field of macro-implementation. Others such as Klein (1980), Ham (1981), Haywood and Hunter (1982), Hunter (1983, 1986), and Hunter and Wistow (1987) have considered the issues in the NHS and stressed the gap between national policy and local strategy.

"There is mounting evidence that governmental, and DHSS, preferences on priorities are not always accorded precedence locally" (Haywood and Hunter, 1982, p. 159).

This research highlights some of the implementation problems at the micro-implementation level. The focus on micro-implementation problems is, however, not meant to be at the cost of ignoring completely the macro-implementation level. The latter will be treated as an important element of the wider context in which the districts operate.

The study investigates the relationship between intended and realised change within local DHAs. A recent contribution by Pettigrew (1985) has been to suggest, and then to illustrate empirically, using the example of a large and complex British firm that

realised change results from the relationship and the interplay between three sets of factors: (1) the content of change; (2) the context of change, which includes both the external conditions and the internal organisational characteristics; and (3) the process of managing change. The context, content, and process framework is guiding this investigation into the closure of GPMUs.

The methodology used to gather data for this research was a form of longitudinal field research developed at the Centre for Corporate Strategy and Change (CCSC), University of Warwick for use in the study of change in both private and public sector organisations (Pettigrew; 1985, 1990). In terms of fieldwork, this approach entailed the analysis of a broad range of documentary and archive material, secondary quantitative indicators, semi-structured interviews with key participants, and observational material.

The Closure of Health Facilities in England

In England, the closure and conversion of health facilities has become an increasingly common phenomenon. As Hardy (1985) pointed out,

"In the public sector, government policies involving massive expenditure cuts have led to redundancies and the reduction of services. In the health services, for example, hospital closures have become relatively commonplace." (p.xi)

The closure of hospitals, however, remains a sensitive political issue. Data on closure in the NHS is not readily available and is disclosed with caution.

"It is important to bear in mind, however, that closures are very often balanced by openings or other reprovision and are not, in themselves, much of an index to anything at all. Again, information of this nature is only available locally".

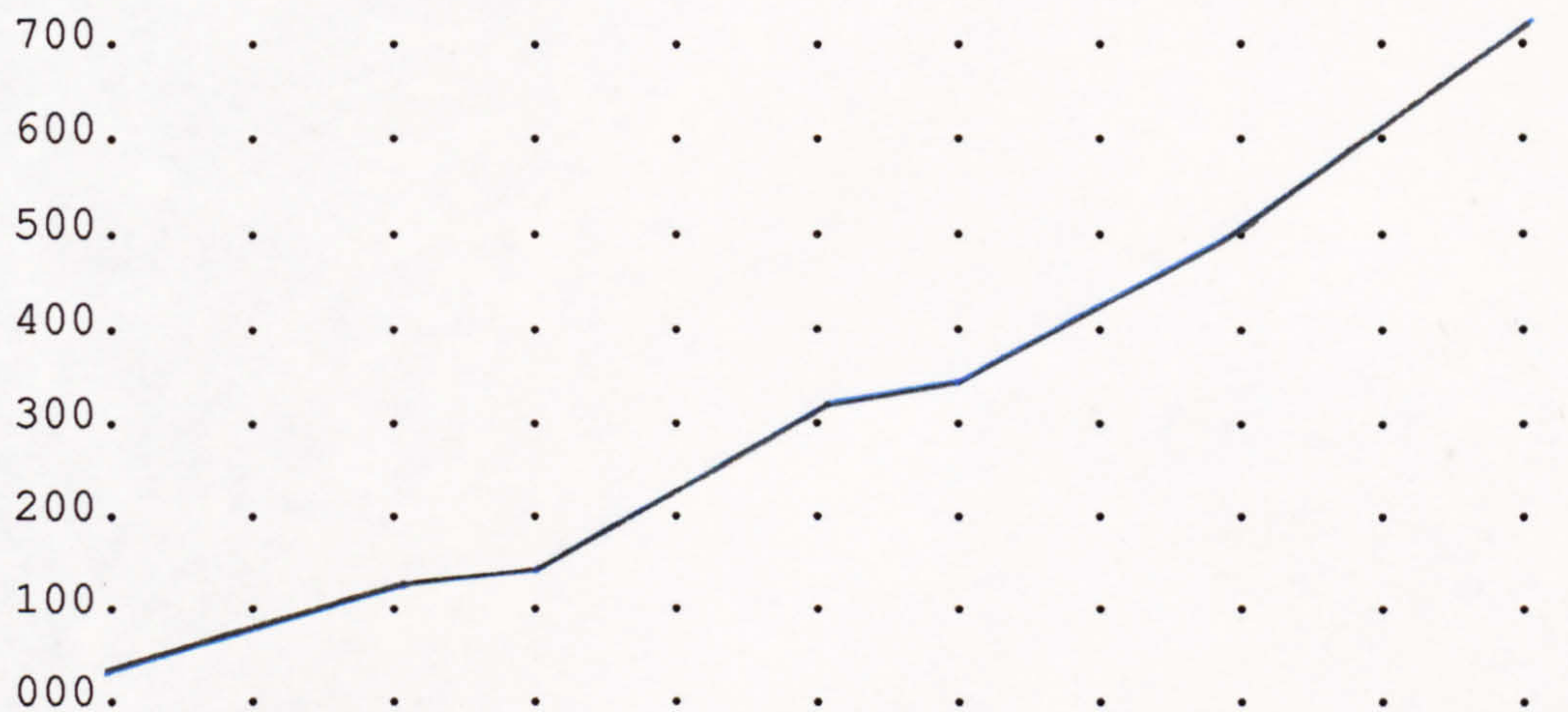
DHSS Senior Officer

In the nine years from 1979-1987, over five hundred hospitals or health facilities were affected by permanent closure proposals. In the last two years alone (1988 & 1989), an additional two hundred and thirty three facilities were closed. (Figure 1-0).

Figure 1-0

Cumulative Number of Total Closures of NHS Hospitals
and Health Facilities, 1979 - 1989.

Total
number of
closures



Years

1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----
n: 35	42	54	22	76	86	43	76	67	132	101

GRAND TOTAL: 734

min: 22
max: 132
average: 66

Source: Data provided by the DHSS.

Partial closure of hospitals is also becoming more frequent in the NHS (see Table 1-0).

Table 1-0

Number of Partial Closure of NHS Hospitals
and Health Facilities

1979 - 1989

6	4	17	4	18	27	19	29	34	72	46
1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989

Source: Data provided by the DHSS.

Yet, despite their prevalence and significance, research into closure phenomena in the NHS has been limited. Anecdotal case reports on some of these closures of health facilities exist and journalistic accounts are plentiful. With a few exceptions, namely those of Korman & Simons (1978), Korman & Glennerster (1985, 1990), Hardy (1985), Tomlinson (1988), and the CCSC's series (Pettigrew et al, 1989, 1990, forthcoming 1991), there is a paucity of British empirical study of the implementation of closure in hospitals.

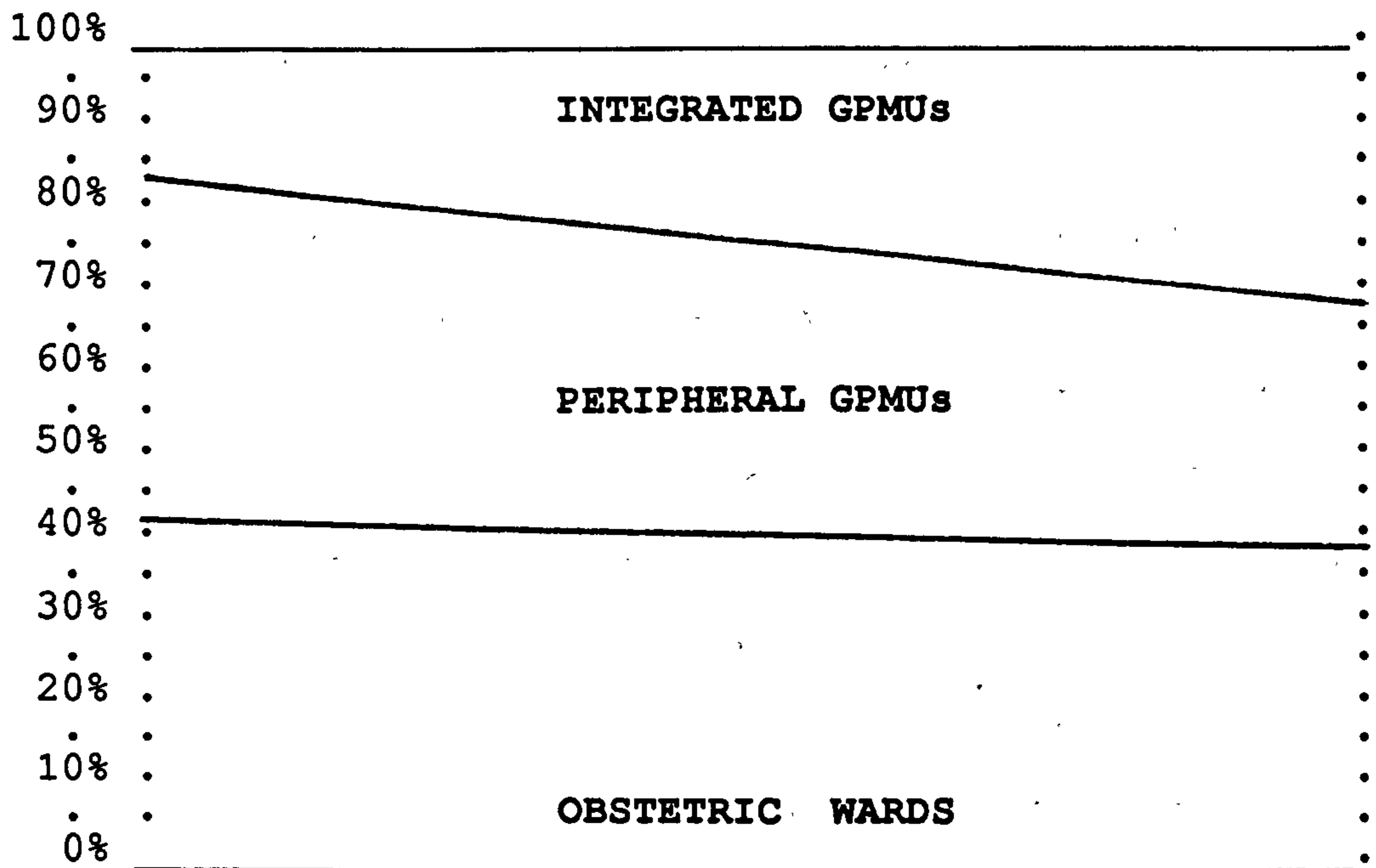
The Closure of GPMUs

The closure of peripheral GPMUs has been a consistent feature of Government policy since the Peel Report in 1970 which stated that they should be replaced by large integrated consultant and GP units (see Chapter five). By the time of the 1974 reorganisation there were 221 peripheral GPMUs which were accounting for over 10% of all births occurring in the NHS hospitals. In 1986, about 2% of all births in England took place in the remaining 94 peripheral GPMUs still in use and the total number of obstetric and maternity units in England represented only 66% of the number of units available in 1973 (Figure 1-1).

Figure 1-1

Proportion of Obstetric and Maternity Units
1973, 1978, and 1985

England



Year	1973		1978		1985	
	n	%	n	%	n	%
Integrated	87	(16%)	106	(25%)	111	(32%)
Peripheral	221	(42%)	148	(35%)	103	(29%)
Obstetrics	219	(42%)	169	(40%)	137	(39%)
	---		---		---	
TOTAL:	527	(100%)	423	(100%)	351	(100%)

Source: Drawn using data provided by the National Perinatal Epidemiology Unit (NPMU), Oxford.

The proportion of peripheral GPMU has decreased from 42% in 1973 to 29% in 1985 whereas the proportion of integrated GPMUs has increased from 16% to 32%. In that respect the policy is being implemented successfully.

The closure of GPMUs is a relatively old and, somehow, less exciting issue as compared to other more recent strategic concerns such as AIDS, the increase of day-care services, and the development of community based psychiatric services. In contrast with these strategic concerns, the closure of a GPMU is a relatively short saga which, if unsuccessful, can be repeated within a short period of time. Closure generally involves, however, more strategic levels of choice than is the case with simple routine decision-making. It falls within the category of "middle-range decisions" (Hunter, 1980).

"The outcomes of middle-range decision at health board level can have an impact on broader, more strategic policy-making activity. Indeed, middle-range decision making is often a substitute for macro-policy making, which aims at a more synoptic approach and one that decision-makers find difficulty in adopting" (p. 6).

The closure of a maternity unit is also a more bureaucratic issue as compared to current strategic concerns as listed above. The circumstances and process of closure are governed by a number of procedures which allow, however, for a fairly wide

variation in the timing, scope, and content of implementation.

The closure of a GPMU is a relatively complex change phenomenon. The closure not only affects the patients, the staff, and the resources directly involved in the provision of the services, but it also has implications for the whole range of supporting services. It has consequences for the practice of some local GPs and midwives. It has to be considered concurrently within the National norms and priorities, the Regional strategies, and the local circumstances and particular past history and tradition. It could hardly be isolated either from other capital and revenue expenditure or from alternative rationalisation and improvements to be achieved in the pattern of services. Besides, clear and indisputable "performance indicators" (PI) to assess and compare local obstetric and maternity services do not exist (Malek & Spencer, 1984; Pollitt, 1985; Campbell & Macfarlane, 1987) and the short and medium range planning of maternity services has proved extremely difficult in the last two decades because of the unpredictable fluctuation of pregnancies from year to year (Mugford & Stilwell, 1986).

The planning procedure leading towards the closure of health facilities has a high level of visibility and involves a large number of parties with various and

often conflicting interests. As Korman & Simon (1978) pointed out:

"Hospital closures entail a decision making process which brings into play judgements on clinical practice, assessment of potential economic gains or losses, compliance with national standards of provision and community needs. These judgements are likely to be made by different groups who may arrive at quite different conclusions about the same situation" (p.147)

The procedure has a high local political and media profile. In order for one District Health Authority (DHA) to close a local health facility, it is necessary that the Authority draws the attention and seeks the reaction of a wide-range of advisory and bureaucratic bodies as well as external interest groups representing employees, consumers, professionals, staff, local authorities, voluntary bodies etc. In some cases the Secretary of State's approval might also be needed to proceed.

The permanent closure of a maternity unit is a collective enterprise involving local interdependent social actors. According to the DHSS's circular which set out the procedures in relation to closure and change of use of health facilities,

"In general, responsibility for determining the closure or change of use of health buildings rests with the Area Health Authority (District Health Authority since the 1982 reorganisation) subject to the formal agreement of the Community Health Council. Where sufficient local agreement exists, it should be possible to move the proposal to close (or change of use) to

actual closure or change of use within a period of six months" (DHSS Circular HSC (IS) 127, p. 1)

The outcome of the process of closure is often uncertain. The previous research on closure particularly in the public sector has shown that few proposals are carried out free from opposition and without any significant modification to the original intent (Bardach, 1976; Behn, 1978; Brewer, 1978; Ellis, 1983).

Inasmuch as maternity service closures are relatively complex and uncertain, decided by interdependent agencies involving many parties with conflicting interests, it may be difficult to implement them successfully.

The Research Contribution

The unique contribution of this research will be to develop an historically bounded, processual and contextual account of the development and fate of four permanent closures of GPMUs in England from 1982 to 1989. The study focuses on the context in which these closure proposals were implemented as well as on the actions undertaken by the proponents of the closure and by their opponents. It highlights the key features and factors which could be associated with the response to, and fate of, the proposals. This will help in answering two basic substantive questions: What affects

the pace of implementation? Why do districts fail or succeed in implementing change desirable by the DHSS in the provision of local health care services?

It is hoped that this research will contribute to knowledge in the area of implementation in a number of ways. First, this research explores and probes the notion of implementation in an empirical sense. There can be no doubt that the debate over what constitutes implementation has not yet been resolved (see Chapter two). In addition, this research deals with the management of change at DHA level, and with the closure of hospital services, both areas where the usefulness of the implementation concept has not been investigated.

More precisely, this research examines those contextual factors and features which constrained the response of four DHAs facing the same longstanding policy: the replacement of small peripheral GPMUs by larger combined consultant and GP units. This area is one where little empirical research of a longitudinal nature has been undertaken. It is hoped that the findings will be of use to future researchers in this area.

Finally, it is hoped that this research will contribute to knowledge because it empirically describes and analyses how some Districts were, or were not, able to implement the proposals. This may permit

other DHAs to avoid some of the difficulties in implementing similar proposals.

Structure of the Dissertation

This chapter has introduced the subject of what this research is about: the gap between statement of intentions and their operational implementation. Chapter two reviews the conceptual foundations and the theoretical perspectives of implementation, together with their advantages and limitations. Chapter three presents the research framework, reviews the existing literature on closure in the NHS and enumerates the main questions that will be dealt with in this study. Chapter four presents the design and methodology used in the research. Chapter five outlines the changing context of maternity services and the general environment in which the closure of the GPMUs took place. Chapters six to nine consist of the empirical description and individual discussion of the four case-studies. Chapter ten takes a broad look at the district's responses to the national policy, outlines the pattern emerging from the case studies, reviews the theoretical approaches to implementation in the light of the empirical evidence of the research, and offers a concluding summary of the key research findings.

CHAPTER TWO

Conceptual Foundations and the Theoretical Perspectives of Implementation

This chapter has three sections. The first section specifies which literature the study draws upon in addressing the broad problem of implementation. The second section summarises and critically evaluates the various theoretical perspectives on implementation to be found in the literature. A summary of the key points emerging from the literature and a discussion of the motives for the diversity of perspectives conclude the chapter.

As Van Meter & Van Horn (1975) indicated, there is a rich heritage from the social sciences that is often overlooked by those attempting to discuss implementation process. The problem is that what is known about implementation is fragmented among several fields of knowledge that cut across a number of academic social science disciplines, including organisational theory and political science (Hrebiniak & Joyce, 1984; Hyder, 1984).

The need to build a bridge between organisational theory and public policy has recently been stressed by a number of organisational theorists (Hall & Quinn, 1983; Pennings, 1985). It has also been emphasised in a number of recent contributions to the health care

management literature (Marmor & Dunham, 1983; Shortell, 1984; Ham & Towell, 1985; Champagne et al, 1987). This research has been guided by the diverse bodies of literature from public policy and organisation theory.

The Concept of Implementation

Implementation has been referred to as an "elusive phenomenon" (Bourgeois & Brodwin, 1984; Lewis & Wallace, 1984). Most scholars view implementation as a stage between a decision and operations and describe it in quite positive terms, such as "making strategy happen" (Stonich, 1982) or "putting ideas into practice" (Hyder, 1984). Ironically, most influential research has mainly used descriptions of failures, mistakes, and breakdowns of implementation (Pressman & Wildavsky, 1973; Bardach, 1977; Berman & McLaughlin, 1978).

There are numerous difficulties in adopting a precise definition of implementation. As Scheirer (1981) indicated,

"A more precise definition is probably impossible without including within the definition some of the analyst's theoretical orientation toward the problem" (p.16).

For instance, Nutt (1986), concurrently adopting a decision making and an organisational development perspective, described implementation as:

"a series of steps taken by responsible organizational agents in planned change

processes to elicit compliance needed to install changes" (p.230)

Other scholars such as Ansoff (1984), Hrebiniak & Joyce (1984), Galbraith & Kazanjian (1986) have written influential books about strategy implementation without feeling concerned about the necessity for conceptual clarification. Their books contain no explicit definition of the notion of implementation itself. These authors use the traditional textbook approach to strategy implementation which treats implementation as a question of organisational design where structures and management processes are manipulated in concert with strategic goals to create a "fit" (Venkatraman & Camillus, 1984) between them.

Of the many definitions, both narrow and wide, the most often quoted in recent British implementation analysis literature is the proposal offered by Barrett and Fudge (1981) and Barrett and Hill (1984). Advocating a Bargaining/Negotiation perspective, they defined implementation as a:

"political process characterized by negotiation, bargaining and compromise between those groups seeking to influence (or change) the action of others, and those upon whom influence is being brought to bear" (p.238).

As some of the fiercest opponents of Barrett and her colleagues' proposals indicated, the main strength of this definition is that it often mirrors the

reality, particularly in the public and human service sectors, by presenting an accurate "description of what happens in real life" (Hogwood & Gunn, 1986, p.207). The main criticism which could be made about this definition is provided by Barrett & Hill (1984) themselves: The proposal retreats from considering the context within which the process takes place. As they indicated:

"We urge that individual empirical studies of implementation must raise questions about their context, we are less clear about exactly how that should be done without enlarging such research activities to such a degree that it may take projects beyond the point of manageability" (Barrett & Hill, 1984, p. 238)

For the purposes of this research, implementation refers to the stream of events, decisions of participants, and actions whereby intents are realised, frustrated, and modified over time within a particular context.

Theoretical Perspectives on Implementation

The following section offers a classification of the various theoretical orientations to be found in the implementation literature.

Elmore (1978) has provided an early discussion of the various implementation approaches available in the literature. Using the idea of alternative organisational models suggested by Allison (1971) he

suggested four distinct models of implementation processes: (1) the system management model; (2) the bureaucratic process model; (3) the organisational development model; (4) the conflict and bargaining model.

The main contribution of Elmore's paper has been to point out that the literature does not support a single analytic model of implementation but a range of complementary models. However, it appears that Elmore (1978) was much more anxious to ascertain whether or not the decision making models provided by Allison were suitable for studying policy implementation than to develop an original and genuine classification of implementation perspectives.

Our review of the literature identifies seventeen differing perspectives for studying implementation (Table 2-0).

Table 2-0

Classification of the Various Implementation Perspectives Into Four Categories

Perspectives

Leading Scholars*

THE CLASSICAL APPROACH

- The Rational Planning Perspective (Kootz & Weighwick, 1990)
- The Decision Making Perspective (Nutt, 1986)
- The Rational Tools Perspective (Bohret, 1987)
- The Ideal Conditions of Implementation (Hogwood & Gunn, 1986)
- The Operational Research Perspective (Naylor & Thomas 1984)

THE CONTINGENCY APPROACH

- The Contingency Perspective (Ginsberg & Venkatraman, 1985)
- The "Fit" Perspective (Galbraith & Kazanjian, 1986)

THE BEHAVIOURAL APPROACH

- The Individual Characteristics (Gupta & Govindarajan, 1983)
- The Strategy-Manager Perspective (Szilagyi & Schweiger, 1984)
- The Diffusion of Innovation Perspective (Rogers, 1983)
- The Cultural Perspective (Lorch, 1986)
- The Organisational Development Perspective (McLean et al, 1982)

THE POLITICAL APPROACH

- The Bureaucratic Process Perspective (Lipsky, 1984)
- The Inter-organisational Perspective (O'Toole & Montjoy, 1984)
- The Bargaining/Negotiation Perspective (Barrett & Hill, 1984)
- The Resource Dependency Perspective (Pfeffer & Salancik, 1978)
- The Symbolic Implementation Perspective (Pettigrew, 1985)

 (*) Example of current leading scholars who have contributed in developing the perspective.

Trying to simplify the question as far as possible, analysis of the alternative perspectives reveals that they cluster into four distinct categories: (1) the classical approach; (2) the contingency approach; (3) the behavioural approach; and (4) the political approach.

In outlining the theoretical perspectives which have been adopted by previous researchers for addressing the question of implementation, it must be stressed that these perspectives are neither mutually exclusive nor independent. They overlap with one another and could be used in a number of combinations to study implementation. However, for the present purpose, they will be treated according to their independent descriptions in the literature.

The Classical Approach to Implementation

The Organisational and the Policy analysis "classical" models (Nakamura & Smallwood, 1980; Korman & Glennerster, 1985) of implementation share the same basic assumptions. As Nakamura & Smallwood (1980) pointed out, during the 1920s and 1930s the policy literature integrated, under the heading of public administration, the principles of scientific management as a comprehensive set of rational precepts to guide the administrative process which was responsible for policy implementation.

The classical approach to implementation rests firmly on the assumptions that the whole process can be controlled from one centre of authority, that formulation and implementation are two sequential and discrete entities with implementation the means of putting intentions into effect, and that efficiency is the basic criterion on which to evaluate administrative performance (Elmore, 1978; Nakamura & Smallwood, 1980; Ansoff, 1984). The assumptions are that once formulated intentions will be implemented as, or nearly as, expected through a highly rationalised structure controlled at the top by a small group of people who have the legitimate right to exercise authority. In other words, the classical model is grounded in the assumption that implementation is a technical, non-political activity which proceeds in response to directives arising from the top.

The classical approach encompasses the following five perspectives: (1) the Rational Planning Perspective; (2) the Decision Making Perspective; (3) the Rational Tools Perspective; (4) the Ideal Conditions of Implementation Perspective; and (5) the Operation Research Perspective.

The first, the Rational Planning Perspective, deals only implicitly with implementation. In this perspective the key element to successful

implementation is the methodical and sequential action involved in planning. The emphasis is placed on recognising the variety and the hierarchy of plans as well as on developing ways of improving the soundness of the planning premises which portray the environment in which the plan is to be carried out. The organisation is assumed to be relatively well-insulated from the rather predictable environment. It also looks for ways of improving the quality of the whole analysis which has to be undertaken before taking any action (Koontz and Weighwick, 1990).

From this perspective, effective implementation requires clearly specified tasks and objectives as well as a management plan that allocates tasks and performance standards (Elmore, 1978). The managers have considerable capacity to change the organisation. The success or failure of implementation is judged by observing the discrepancy between stated intentions and outcomes. As Korman & Glennerster (1985) pointed out, it is assumed that "if outcomes differ from intentions something has gone wrong." (p.5)

As Champagne et al (1985,1987) pointed out, this perspective represents the traditional textbook approach to management and planning. The adherents of this perspective such as Lorange & Vancil (1976), Steiner (1979), among many others, advocate a number of

strategic planning processes based on principles of rational decision making. They also prescribe ways of coupling strategies to operating plans (Hobbs & Heany, 1983). The prototypical process includes the following steps: (1) assessing the opportunity; (2) setting objectives and goals; (3) identifying alternatives to achieve them; (4) deciding which one to implement; and (5) formulating supporting plans and making budgets. It is assumed that purpose and integrated decisions, actions, and plans are essential for a firm's long term success.

The Decision Making Perspective, proposes finding out the possible determinants of implementation outcomes in the various stages of the decision making process. The key element in successful implementation is to make the right decision using a highly rational process. Therefore, the emphasis is placed on improving the efficiency and effectiveness of the sequence of decision-making stages in which the people or the organisational unit involved should go through. Furthermore, the advocates of this perspective such as Horvath & McMillan (1979), Mazzolini (1980, 1981), Fahey (1981), Nutt (1986), among others, highlight the appropriate activities in each strategic decision making step.

The number, the significance, and the boundaries of the steps varies significantly according to the various authors. These steps typically include: (1) problem formulation; (2) development of alternative solutions; (3) selection; and (4) authorisation and installation.

The focus is on the processes surrounding the decision with much less emphasis on the implementation phase itself. As Nutt (1986) indicated, because steps taken to ease implementation can be found in any stage of the process, each stage provides "a window through which implementation tactics can be viewed" (p.234).

The third perspective, the Rational Tools Perspective, considers that the key element to successful implementation is the appropriate process and procedures incorporated into the relevant managerial techniques. As Hogwood & Gun (1986) indicated, the procedures involved are those of scheduling, planning, and control. Therefore, failure of implementation would be lapses of planning, specification and control.

Integrated planning and budgeting systems of the Planning Programming Budgeting System type (PPBS), Local Authority Corporate Planning, Joint Strategic Planning, and Zero Base Budgeting (ZBB) are among the many managerial techniques advocated but adopted more

or less successfully by government agencies to secure rationality in both decision making and implementation. Other managerial techniques such as managing by objectives and performance appraisal, payment schemes, incentives and rewards systems, have also been advocated as means to improve implementation. Most techniques for strategic analysis or approaches to corporate strategic management such as the BCG portfolio model, the GE McKinsey Matrix and PIMS analysis could roughly be classified in this category. It is assumed that the management techniques increase comprehensiveness of planning and, therefore, reduce incrementalism in implementation. Implementation consists of using management control via procedural/managerial techniques to hold agency accountable for the achievement of well-defined standards of performance (Elmore, 1978).

The fourth perspective, the Ideal Conditions of Implementation Perspective assumes that implementation failure could best be avoided or compensated by identifying the deviations from the perfect conditions of implementation. The assumption is that once one has become aware of the constraints which tend to impede implementation, one can undertake action to avoid them. As Hogwood & Gunn (1986) pointed out, the perspective deals with entities which nowhere exist in real life

but in contrasting the real world with an ideal type it is intended to improve the understanding of the practical difficulties of implementation.

The promoters of this perspective such as Hood (1976), Dunshire (1978), Gunn (1978), Chase (1979), and Hogwood & Gunn (1986) have tried to form an ideal picture of implementation derived from the classical theory of bureaucracy as a rational form of human organisation. The list of preconditions necessary to achieve perfect implementation includes adequate time, sufficient and available resources, absence of external circumstances imposing crippling constraints, minimal dependency relationship, valid theory and direct relationship between cause and effect, understanding of the problem to be solved and agreement on objectives, perfect communication and co-ordination, perfect compliance and the like (Alexander, 1985; Howood & Gunn, 1986).

The fifth perspective, the Operational Research Perspective, represents an abstract and logico-deductive construction of implementation. It uses simulation of implementation through mathematical models which focus on prescribing the best decision concerning the course of action to reach a specific intended outcome.

Ceteris Paribus, the Operational Research Perspective provides the opportunity to investigate in advance the consequences of a set of assumptions regarding the implementation process. Therefore, it allows an analysis of a wide range of possible contingencies of choice and strategies of implementation. It is assumed that the outcome of the implementation process can be known in advance by reducing or controlling the significant variables associated with the implementation process. In such a perspective, all significant factors are known, and the problem for the top decision-makers is one of optimising in the light of the myriad facts.

Recent policy implementation research and theoretical development such as the studies of Elmore (1980), Barrett & Hill (1984), and Whitmore (1984) pointed out that the classical hierarchical approach to implementation fails to capture the interactive relationship between formulation and implementation as well as the political dimension of formulation/implementation processes. They also stressed that the distinction between means and ends is blurred, fuzzy, and often broken since "at various points throughout the policy process, what is given as means for one set of actors may be considered as ends by others" (Whitmore, 1984, p.241). NHS analysts such

as Ham (1981), Haywood & Hunter (1982), Hunter (1983, 1986) also stressed the failure of conventional hierarchical top-down models to account for the implementation gap.

According to Elmore (1978) one of the main weaknesses in the classical approach is that it fails to account for the lack of management control across jurisdictional boundaries. Its most important weakness is, however, its lack of descriptive validity.

"all propositions on which the model is based are normative; they describe how organizations ought to function, not necessarily how they do ... it is dangerous, however, to focus on the normative utility of the model to the exclusion of its descriptive validity. To say that the model simplifies in useful ways is not the same thing as saying that the implementation process should be structured around the model. This is a mistake that policy analysts are particularly prone to make ... (Elmore, 1978, p. 199)

Attacks against the classical approach have also been made by Organisational Theory critiques. One of the major criticisms issued has been that the classical approach uses relatively mechanical closed-system assumptions which fail to consider the environmental influences as well as many important internal aspects of organisation (Thompson, 1967; Pfeffer & Salancik, 1978).

Miles et al (1974) indicated that for the first half of this century organisation theorists tended to

ignore the environment or at least to hold it constant. Throughout those years, the research on organisation has been inclined to explain organisational outcomes mainly in terms of factors within the organisation itself. According to Hardy (1985):

"A perspective such as this is incomplete because it ignores the fact that the internal workings of an organisation are affected by external forces as well as by factors inside the organisation" (p.2).

However, the most obvious criticism of the classical approach of implementation concerns the ubiquitous presumption of rationality in decision making behaviour. As Bourgeois & Brodwin (1984) indicated, in this approach the role of the decision-maker is that of a rational actor issuing directives from the seat of power. To succeed the organisation needs to be tightly coupled so that the decision made at the top can be implemented throughout the organisation enabling intentions to become actions. However, empirical research into management decision making has provided clear indications of psychological and organisational limits to rationality in real-life decision-making (Pettigrew, 1973; March & Olson, 1976; Quinn, 1980). Rational decision making affords a bad basis for action rationality. Furthermore, many parts of large and complex organisations such as educational facilities, hospitals and other public institutions

have proved loosely coupled and, as a result, intractable to analysis and action through rational assumptions (Weick, 1976; Gaertner et al, 1984).

In summary, recent literature in both fields, Policy Analysis and Organisation Theory, has severely questioned the conventional linear assumptions regarding the implementation process. As the strategic problem came to be seen as much more complex, the emphasis is moving away from the classical approach to implementation (Chaffee, 1985). A plea for considering environmental and contextual forces which constrained the internal workings of organisation has recently been made. In order to understand and explain the gap between stated intentions and the realised outcomes additional variables must be incorporated into the stream of research on implementation process.

The Contingency Approach to Implementation

The contingency approach is the prevalent approach to implementation in the strategic management literature. The basic premise of this approach is that an organisation has a variety of unequal effective structural forms and organisational processes from which to choose when implementing a particular strategy (Galbraith & Kazanjian, 1986). In this approach, the role of the decision-maker is that of an architect,

designing administrative systems to implement strategic change (Bourgeois & Brodwin, 1984).

The model of the organisation as an open system is at the foundation of this approach to implementation. According to the open system theory, the organisation acquires its input from the environment and after having engaged in through-put processing, dispenses its output to the environment (Katz & Kahn, 1966). The open system model of organisation has expanded the classical research concerns to include the exchange relationships between organisation and its environment as well as the effect of organisation-environment interface.

The contingency approach to implementation assumes that a mismatch between the organisation and its environment may prove detrimental to the organisation in either the short or long run. On the other hand, success in aligning the organisation with its environment may prove profitable. According to Christensen et al (1978), who have been among the leading scholars in the field, the main implementation task is to design and to make effective "an organisational structure appropriate for the efficient performance of the required tasks" (p. 130).

The contingency approach rests mainly on the same set of assumptions as the classical approach. In fact, the contingency approach offers an extension to the

classical approach. As Bourgeois & Brodwin (1984) indicated, this approach starts where the previous one ends: with implementation. Like the classical approach, the contingency approach considers implementation as a series of technical, non-political, administrative activities.

The contingency approach of implementation encompasses the following two main perspectives: (1) the contingency perspective; and (2) the "fit" perspective.

The contingency perspective of implementation is essentially determinist. In this perspective situational or contextual variables such as environmental uncertainty, technology or size automatically determine structure. As Astley and Van de Ven (1983) pointed out:

'Contingency theory assumes that contextual constraints have binding effects on organisational operations. In other words, context has causal primacy; management merely responds in the technically appropriate manner.' (p 253)

The key to successful implementation is to design an organisational structure which is best adapted to the characteristic of both its external and internal contexts. Therefore, the emphasis is placed on assessing the organisational attributes, tasks and environment and on adopting the appropriate structural

form. The organisation must change with the environment.

It is further suggested that organisations which succeed more speedily and effectively in implementing change can be distinguished from the others by a number of characteristics referring to managerial and organisational attributes (Daft, 1982; Gaertner et al, 1984). These have been broadly described by Burns & Stalker (1961) and later writers under the label of "organic" as opposed to "mechanistic" structures the former being appropriate in an uncertain or fast-changing environment while the latter is suitable in a time of stability. As Hogwood & Gunn (1986) suggested, the organic structure seems relevant to those implementation situations in which the decision-makers are concerned to design structures capable of implementing a sequence of change over time, but considerations such as the scale of many governmental agencies and the demands of accountability make it difficult to use within the public sector.

The second perspective, namely the "fit" perspective, pushes the contingency perspective further. In this perspective key internal administrative and organisational mechanisms are put in line with an intended strategy. The framework that best illustrates the theoretical basis of that

perspective is the McKinsey Seven "S" Framework (Peters and Waterman, 1982).

The implementation elements are derived on the backcloth of a given strategy. An important assumption underlying this perspective is that these elements can be consciously designed to constitute an internally consistent organisational form (Miles & Snow, 1984) which, in turn, could have a crucial impact, especially under competitive conditions. Criticisms relate mostly to the relative neglect of the external influences to the organisation on the implementation and to the one way alignment between strategy and the internal structures and management processes (Venkatraman and Camillus, 1984).

Above all, the contingency approach does not diverge from the rational actor model. The firm is composed of omnipotent managers who speak with a single voice. The general manager is the rational processor of the various demands on the organisation. Strategy, structure and processes are assumed to be neutral features of organisations, and the environment itself is presumed objective. As Bourgeois & Brown (1984) suggested, the approach fails to deal with problems of obtaining accurate information, nor does it resolve either the motivational problems or the lack of political considerations of the classical approach. The

political dimension of the formulation/implementation processes is ignored with little recognition that an issue is influenced by the others at any point across the formulation/implementation continuum.

Furthermore, evidence from empirical research is neither conclusive nor adequate to support a simple deterministic relationship between the strategy, the structure and the environment. Depending on which body of empirical evidence is used and on which part of the strategic process is observed, both "structure follows strategy" and "strategy follows structure" can be valid propositions (Pettigrew, 1985).

The Behavioural Approach to Implementation

As Hogwood & Gunn (1986) pointed out, there are some limits to what can be achieved in implementation by manipulating structures and procedures: human behaviour must also be influenced.

The behavioural approach is grounded in the belief that there are some significant individual and organisational sources of resistance that must be overcome in implementing changes. The features that matter most are those that affect individual motivation, commitment, and interpersonal cooperation in implementation.

The behavioural approach encompasses the following perspectives: (1) the Individual Characteristics

perspective; (2) the Strategy-Manager Matching perspective; (3) the Diffusion of Innovation perspective; (4) the Corporate Culture perspective; (5) the Organisational Development (OD) perspective and the Organisational Change and Development (OCD) perspective.

The individual characteristics perspective assumes that implementation outcomes are determined by one main set of factors: the personal variables which characterise the people who are involved in the process. This perspective stems from the psychological literature on attitudes, attitude change and behaviour.

As Champagne et al (1987) indicated, the proponents of this perspective postulate the existence of a sequential relationship between individual characteristics and behaviour. Personality traits, attitudes and values, are presumed to influence the implementing staff members' willingness to foster and to implement changes. For instance, using a survey design, Gupta & Govindarajan (1983) studied how managers' attitude toward risk would affect the success of strategic implementation and found a significant relationship between risk-taking and success in implementation. This view of implementation is rather inadequate.

"It is not dynamic, it does not examine the process of implementation, and comes

dangerously close to a trait theory of strategic leadership. It is far removed from organisational reality, and it takes a monodimensional view" (Voyer, 1986, p. 18)

Interest in the individual characteristics perspective reached its peak early in the 1960s and significantly waned in the early 1970s. The direction of influence between changes in individual variables and change in behaviour remained debatable (Schuman-Johnson, 1976). Some scholars such as Calder & Schurr (1981) and Pfeffer (1982) have emphasised the need for understanding attitudes in context.

"Attention to the context in which dispositions (such as attitudes) and perceptions of the environment are formed is a critical deficiency in the various perspectives of individual rational choice"(Pfeffer, 1982, p.75)

In recent business policy literature, the assumption that senior staff's personal values and aspirations do play an influential role in the formulation and the implementation of strategies has led to increasing attention to the managers' characteristics and to the matching of managers to strategies.

According to the proponents of this perspective of implementation (Wissema et al, 1980; Szilagyi & Schweiger, 1984) emphasis should be placed on selecting managers for implementing strategies whose personality traits, cognitive style, behavioural characteristics,

and personal values are congruent with the requirements of particular chosen strategies. It is assumed that managers lack the flexibility to adopt a range of managerial behaviour and style and to function effectively in implementing various types of strategies (Wissema et al, 1980).

The various Strategy-Manager Matching models could be criticised on various major points. First, in most matching models the meaning of the concept of strategy is taken for granted while it may well be considerably different from one manager to the other.

Second, managers could be matched to strategies only if managerial personality traits and other important managerial characteristics can be accurately identified and measured. Furthermore, it would be beneficial to match managers to strategies only if specific personality traits associated with successful strategy implementation are known. The notion of value offered by the Harvard Business Policy scholars such as Christensen et al (1978) was intended to reassert the influence of managers as different individuals in the strategic management process. However, the conceptual clarity and the supporting research evidence concerning the validity of the contentions and prescriptions offered by the various matching models is still largely missing.

Third, other relevant factors or "matching contingencies" (Tichy, 1983) such as organisational culture and power, structural boundaries, and various systems, must also be considered in selecting senior managers. As Galbraith & Kazanjian (1986) indicated, the matching manager to strategy perspective assumes that there are no major social or political dysfunctions associated with changing top managers and general managers in particular as the strategy changes. Although empirical research does not exist, this latter assumption could be challenged on a commonsense basis as well as on real life evidence particularly in public services.

The third behavioural perspective, the diffusion of innovation perspective, also stresses the role of the individual in implementing change. However, it shifts its main focus from the personality traits to the role and skills of the leaders and the implementation techniques (Nord and Tucker, 1987). It is generally assumed that the way changes are communicated to the people who are affected by them, and the role of the opinion leaders and "product champions" (Coleman et al, 1966; Stocking, 1985) are critical in facilitating or impeding change and use of innovation.

Unfortunately, the main focus of the research on innovation has clearly been on predictors of innovation adoption as an outcome and the empirical research did not directly illuminate the problems of implementation process as a critical factor (Forrest, 1977; Scheirer, 1981; Gaertner et al, 1984). Furthermore, the majority of the studies have focused on technological innovation in contrast to organisational and managerial innovation. Because of significant differences between technological and organisational innovations (Draft, 1982), the empirical research findings cannot simply be transcribed from one type of innovation to the other.

The literature on innovations in health care organisations has also traditionally focused on the diffusion of technological and medical innovations. The central interest has been in the adoption or rejection of specific therapies and procedures (Coleman et al, 1966) by individual practitioners and the unit of analysis has been the innovation itself rather than the organisational context.

The diffusion of innovation perspective has been essentially anthropocentric at the expense of the organisational and environmental determinants of the adoption of innovation and change (Elkin, 1983). As Pettigrew et al (1988) indicated, the diffusion of innovation perspective's lack of an organisational

focus and its low sensitivity to the structural and environmental variables have made it less able to handle strategic issues where changing resource flows and dominant organisational coalitions assume importance.

The fourth behavioural perspective, namely the corporate culture perspective, is the latest wave of explanation for the success or failure of implementation (Bourgeois & Brodwin, 1984). A corporate culture is a set of beliefs shared by managers about how they should manage people and conduct their business (Schein, 1985; Lorch, 1986). The assumption is that distinctive corporate cultures are responsible for the ability of devising and implementing change successfully (Tichy, 1983; Peter & Tseng, 1983; Bice, 1984).

In this perspective, the corporate culture is seen as a potentially powerful source of resistance to change in shifting strategic direction (Allaire & Firsirotu, 1985) as well as a critical lever which could be used to mobilize and channel the energies of organisational members (Smircich, 1983). The implementation of significant and discontinuous changes would require some sort of rethinking of the system of beliefs. Otherwise, the corporate culture could become an "invisible barrier" (Lorsch, 1986, p. 95) which

would inhibit the needed change. The main challenge becomes to know how either to mould and shape internal culture in particular ways or to change culture, consistent with managerial purposes. As Bourgeois & Brodwin (1984) indicated,

"it would appear that with an organisational culture in place, the implementation task is 90 per cent done" (p.251).

The basic assumption that distinctive corporate culture is responsible for success is based upon the study of institutionalised managerial practice used either in successful Japanese firms or in successful American companies. There has been considerable debate over the validity of these studies (Shortell, 1985).

The assumption that the management has the capacity both to adjust and alter the organisational culture in a planned way has also been questioned (Pettigrew, 1986). The corporate culture perspective uses a too mechanistic notion of organisational culture.

"The talk about corporate culture tends to be optimistic, even messianic, about top managers molding cultures to suit their strategic ends. The notion of corporate culture runs the risk of being as disappointing a managerial tool as the more technical and quantitative tools that were faddish in the 1970s" (Smircich, 1983, p.346).

The fifth behavioural perspective, the Organisational Development perspective (OD), is the best known attempt to apply the conceptual groundings of behavioural science to the management of organisations. OD has been practiced in industrial corporations since the 1950s but is relatively new in public organisations as well as in hospital settings (Marguillies & Adams, 1982; McClure, 1985).

OD has changed considerably since its emergence in the 1950s (Greiner, 1977; Pettigrew, 1985). It is beyond the scope of this chapter to review in detail the stages of the OD evolution. Besides, Pettigrew (1985) has recently synthesised the extensive literature on OD practice and theory.

For the purpose of this research two broad OD patterns of thought can be distinguished: (1) the classical OD perspective of implementation; and (2) the contemporary Organisational Change and Development (OCD) perspective of implementation.

The classical OD approach (Bennis, 1969) arose from humanistic psychology. Relying on educational strategies emphasising experiential behaviour, the classical OD perspective seeks organisational change through changes in people variables such as attitudes, interpersonal relations, and organisational climate. As a process for bringing about organisational change,

the classical OD approach assumes that change induced by individual staff members who are key to successful implementation is more likely to be achieved than change arising from external sources.

Implementation failure and success can be gauged by looking at the extent to which implementers were involved in the formulation, the extent to which they are encouraged to exercise independent judgement, and the extent to which they use face-to-face work groups for mutual support and problem solving. Implementation failures are the result of lack of consensus and commitment among implementers (Elmore, 1978).

The classical OD perspective has been widely criticised. For instance, its objectives and methods have been described as conservative, manipulative, intrusive, and primitive (Strauss, 1976). It has been criticised for its lack of empirical foundations (Kahn, 1974) as well as for failing to consider the divergence in interests and conflict (Blackler & Brown, 1980). It has also been criticised for its reductionistic scope: the classical OD approach has been obsessed with the people variables (Stephenson, 1975) to the exclusion of temporal, procedural, and contextual factors and features (Pettigrew, 1985).

The parameters of the emerging contemporary OCD perspective are not well established yet they already

appear much more complex than the parameters of the classical OD perspective. A recurring theme in the recent literature suggests that it starts where the classical OD perspective ends: with the contextual variables. Intraorganisational context and the conditioning and enabling influence of the social and economic environment are promoted as facilitating and constraining the processes of organisational change.

In fact, in recent years, the concern of the scholars has moved on from the rational analytical schemes of internal intended planned changes to the understanding of the variety of process modes of strategic change.

The main interest of the scholars is still on "policy centred" or "top-down" implementation and on overcoming the resistance in managing strategic change in structure, systems and process (Kotter & Schlesinger, 1979; Ansoff, 1984; Lippitt et al, 1985). But the focus of the fundamental research has moved beyond the study of change episodes to the analysis of various organisational change processes such as the organisational learning processes (Argyris & Schon, 1978), the corporate transition processes (Kimberly and Quinn, 1984), the processual dynamics of changing and continuity (Pettigrew, 1985), the institutional change processes (Hyman, 1984; Zucker, 1987), and the context

and process of organisational transformation (Child & Smith, 1987).

The empirical process researchers such as Pettigrew (1977), Mintzberg (1978), Quinn (1980), and Kanter (1983), among others, have shown that strategic change processes are best described as multi-level activities. The research also indicated that the outcomes of these processes are shaped by a wide range of variables as opposed to a product of rational debates involving a few or even a single general manager. However, as Pettigrew (1987) recently indicated, there has been a tendency among the pioneers of this perspective to focus on the link between the process of change and the internal structure, corporate culture, and political context at the expense of the explanatory role of the outer larger context and content of strategic change.

Recent research such as the studies of Pettigrew (1985), Hardy (1985), Johnson (1987), and Child & Smith (1987) have included these variables in their research framework. They have already been criticised for defining their context too narrowly (Whittington, 1989).

"Though these authors may sometimes refer to national cultural characteristics - as for instance, in Pettigrew's (1985) linking of OD's success within ICI in the 1960s to a general cultural atmosphere of liberalism and tolerance - they fail to connect such factors

to any systematic account of wider social structure. The tendency is to adopt an economistic atomism. Thus the ways in which social structures of class or gender may be mobilised by managers in obtaining important outcomes are systematically ignored" (p.70).

The body of contextual empirical studies is still limited and of an exploratory nature. These studies have provided some outstanding monographs of strategic change. Thus far the contribution has remained essentially descriptive.

"However, useful as this process research has been in descriptively analysing how significant changes are made, with the exception of Quinn (1980, 1982), Kanter (1983), and Pettigrew (1985) few of these process researchers have tried to build on their descriptive analyses and pinpoint some of the key prescriptive features of managerial strategy required to create substantial changes in manpower, structure, or strategy" (Hardy & Pettigrew, 1985, p.13).

Pettigrew (1985, 1987) has recently pointed out that the principal shortcoming of the literature on organisational change and development is its ahistorical, acontextual, and aprocessual treatment of change.

"As with so many other areas in the social sciences the empirical findings and theoretical developments in the field of organisational change are method-bound. For as long as we continue to conduct research on change which is ahistorical, acontextual, and aprocessual, which continues to treat the change programme as the unit of analysis and regard change as an episode divorced from the immediate and more distant context in which it is embedded, then we will continue to develop inadequate descriptive theories of

change which are ill-composed guides for action." (p.15)

This major criticism directed at the organisational change and development literature is very much the same for all the perspectives associated with the behavioural science approach, with the exception of the fundamental OCD perspective which is only just beginning to gather momentum.

Furthermore the applied behaviour science theory has been basically apolitical. Most of the behavioural perspectives, with the exception of the contemporary OCD perspective, systematically avoid the problem of power, or do not consider the influence that conflicting interests within and outside the organisation may have on the efficiency of the implementation strategy.

The behavioural approach would seem most appropriate under conditions that favour collaboration. However, it clearly overlooks the role of conflict under differing conditions, such as when the pattern of resource sharing is threatened, when opportunities to seize new resources are opened up, or when resources decrease.

Political Approach to Implementation

The political approach to implementation is primarily concerned with the impact of patterns of

power and influence on the implementation processes and outcomes. As opposed to the other approaches introduced thus far, in the political approach, conflict and bargaining are considered as endemic rather than exceptional or pathological features of organisations. The focus is not on the resolution of conflict but on the strategy and tactics used by individuals and groups to make the best of it.

The political approach assumes that, as a result of the division of labour, a plurality of at least partly conflicting interests exist within and among organisations. These interests would become manifested through the quest for control over the real or symbolic organisational scarce resources (Pettigrew, 1973).

The implementation outcomes reflect the relative strengths of the interest groups at a particular moment of time. In the last resort, successful implementation would depend on the ability of a particular group or a coalition of various groups promoting specific interests to generate enough power and thereby to impose its will on the others. However, because implementation outcomes are the result of bargaining and compromise between the various interest groups involved, they rarely represent perfectly the interests and original preferences of any single actor in particular.

As Hogwood & Gun (1986) indicate, the basic argument is that implementation may have been carefully planned in terms of structure, systems and influence on behaviour, but if it takes insufficient account of the powerful internal and external interests then the implementation is unlikely to succeed.

The political approach encompasses the following perspectives: (1) the bureaucratic process perspective; (2) the inter-organisational perspective; (3) the bargaining and negotiation perspective; (4) the resource dependency perspective; and (5) the symbolic implementation perspective.

The first political perspective of implementation, namely the bureaucratic process perspective, traces the effect of lower-level discretion and routinised behaviour on the implementation of change (Lipsky, 1974). According to Scheirer (1981) this perspective might be more accurately termed the "bureaucratic-political explanations for non-implementation" (p.29) since it has mainly been used by the scholars to explain the failure rather than the success of policy implementation.

Because of the frequency and immediacy of the contact between the client and the "street-level bureaucrat" (Lipsky, 1984) - one who is in direct contact with clients and who takes decisions over

client treatment - it is difficult for higher level administrators to monitor or control their actions and performance. Clients' control is also relatively limited because of their dependence on the bureaucrats to mediate their needs to the organisation.

In this perspective, autonomy and discretion increase as one moves down the hierarchy, the strategy comes upward from the rank and file rather than downward from the top, and therefore the "participation managed planning is the preferred implementation approach" (Nutt, 1983, p. 605). The problem revolves around the top managers' ability either to devise more sophisticated ways of bounding and controlling discretion (Weatherly & Lipsky, 1977) or to define organisational purposes broadly enough to encourage innovation and to establish an incentive scheme to encourage operating managers to make decisions that will further the long-range interests of the organisation (Bourgeois & Browning, 1984).

The success or failure of any top-down implementation attempt would depend on whether the force of existing routine at the point of delivery operates with or against the proposal to be implemented.

The main strength of the bureaucratic process perspective has been to identify and explore the

existence and source of power through functional, professional, and organisational autonomy. However, the perspective tends to heed the technical skill and knowledge at delivery level and to overlook the other sources of power, such as control over long term allocation of resources and the legal prerogatives held by other influencers such as the central government and local authorities in implementing change.

"Central government clearly has access to legislative resources not available to local authorities and can use these not only in relation to the implementation of a particular policy but to change the rules of the game in which relationships are normally conducted (such as the right to be consulted, the basic grant structure) or even to change or abolish other political actors, as with the re-elected 1983 Conservative Government's plans to abolish the Greater London Council and the metropolitan counties. The fact that one organisation in an implementation relationship has a preponderance of resources does not exclude the likelihood that it will be dependent on other organisations for key aspects of implementation" (Hogwood & Gunn, 1986, p. 217).

Furthermore, the study of implementation has been confined to the behaviour of actors in their organisation roles and setting, neglecting the wider context which determines both the power base wielded by the street level bureaucrats and the way that individuals and groups interact with each other in the process of operating routine.

The second perspective of the political approach, the inter-organisational perspective, suggests that implementation results not from the actions undertaken by a single organisation but rather from the joint actions undertaken by a set of organisations. These structures are comprised of individual implementers from different organisations who must coordinate their decisions and actions or must co-operate one with another in order to carry out a particular proposal.

"The number of organisations and the need for coordination across organisations make the situation much more complex, ceteris paribus, than in the single agency case" (O'Toole & Montjoy, 1984, p. 492)

In the literature on inter-organisational implementation, the emphasis has been initially placed on the number of necessary linkages which have to be made in securing implementation. That kind of analysis has been well summed up by Elmore (1980):

"With a sharp pencil, a good eye for detail, and a pocket calculator, one can demonstrate without much trouble that any policy will fail, simply in counting the number of discrete clearances and decisions, assigning a probability to each, and multiplying them seriatum" (p. 608).

The empirical basis for such calculation has been provided by Pressman & Wildavsky's (1973) study. Their research suggested that the effects of factors inherent in the nature of bureaucratic organisations would tend

to be compounded by the number of veto points, and the ability to induce actions would decline as the number of agencies increases.

The main contribution of this first step in the development of the inter-organisational perspective has been to stress the effect of the agreement among a large number of participants over the outcome of the implementation processes. However, the process of simple arithmetical calculation is a little misleading.

"Pressman & Wildavsky's calculation was based on an "all-or-nothing" concept of a favourable outcome at each decision point, whereas the chances of partial success might well be higher. That being said, it still seems likely that the greater the number of clearances required among other bodies involved in implementation, the lower will be the chances of full implementation" (Hogwood & Gunn, 1986, p. 203).

Additional development and research such as the studies conducted by Bardach (1977), Radin (1977), and Hardy (1985) indicates that the chances of successful implementation can be either greatly improved or impeded by a variety of manoeuvres and counter-manoevres performed by the various parties involved in the processes. This is grossly overlooked in the simple process of arithmetical calculation.

The inter-organisational perspective has been further developed within two other political perspectives of implementation: (1) the conflict and

bargaining perspective; and (2) the resource dependence perspective.

The model of implementation as conflict and bargaining focuses on the nature of interactions taking place among multiple participating actors and agencies as well as on their interests, relative autonomy and tactical use of power to retain or obtain control over resources.

The proponents of this perspective such as Bardach (1977), Barrett & Fudge (1981), Barrett & Hill (1984) stress the complexity and ambiguity of both the proposals to be implemented and the negotiative processes involved in implementation. The proposals themselves are simply a point of departure for bargaining among implementing agencies.

Implementation often takes place in absence of clearly defined goals and without clear focus of power to resolve the issues. The various parties involved have only an imperfect understanding and knowledge of the other motives and resources.

Success or failure of implementation is a relative notion determined by the actor's position in the process itself. The outcome is simply a convenient temporary agreement which reflects no overall agreement on purpose but which brings expectations into momentary convergence and takes negotiation to closure.

"Bargained decisions proceed by convergence, adjustment, and closure among individuals pursuing essentially independent ends ... The mechanism of convergence depends on the interdependence of expectations. Parties to the bargaining process must predicate their actions not only on predictions on how other will repond but also on the understanding that others are doing likewise. So bargaining depends as much on shared expectations as it does on concrete actions" (Elmore, 1978, p.220).

The major contribution of this perspective has been to highlight the complexity and ambiguity of implementation. However, the perspective has come under fire from two directions. On the one hand it has been criticised for being long in description and short in prescription (Elmore, 1980; Hogwood & Gunn, 1986). On the other hand, it is attacked for relying on "soft" methodologies leaving open the questions of causal inference and generalisability (Hood, 1982).

"The explanatory power of the blurred-sector, bargaining-exchange, multiple-actors vision of policy, as it stands, is at best trite. It is a picture, not a theory ... Stressing complexity is a cop-out" (Hood, 1982, p. 369).

A view of implementation that emphasises complexity such as the bargaining perspective requires further work towards the specification of its elements (Barrett & Hill, 1984).

The resource dependence perspective argues that the organisational behaviour becomes externally constrained because the organisation must attend to the

demands of those in its environment that provide essential resources to attain its self-interest objectives (Pfeffer & Salancik, 1978). It is assumed that dependence of organisations increases with the degree to which resources are scarce or irreplaceable, and with the extent to which transactions are institutionalised or controlled by only a few groups.

The foremost premise of this perspective is that implementation, like all other organisational activities and outcomes, is accounted for by the specific context in which the focal organisation is embedded. This context is made up of the set of various organisations with which the focal organisation interacts in order to secure its access to necessary and important resources.

Thus far, the empirical research has either tested the fundamental assumption regarding the link between control over resource and the development of inter-organisational power and influence or investigated the various specific means and strategies undertaken by an organisation to cope with external constraints resulting from resource dependence and for managing dependencies. The compelling empirical evidence has been consistent with the theory presumption concerning compliance to external constraints. It has also supported the prediction regarding the management of

external dependence. Most of this empirical research has been reviewed and summarised by Pfeffer (1982).

While the resource dependence perspective does locate the cause and effect of organisational interdependence, it overlooks the process which links them together. The perspective contributes to the understanding of the ties between organisations and accounts for why organisational networks have formed and developed but disregards almost completely how this has been done. In other words, it neglects the dynamic aspect of the interface between the organisations involved.

Furthermore, despite the fact that the perspective suggests that the organisational activities and outcomes are accounted for by the context in which the organisation is embedded, it does not include a concern with the larger societal context and its institutional arrangements (Benson, 1982; Pettigrew, 1985).

"There is a tendency to develop a general theory of resource dependencies applicable to educational, religious, political, and economical organisations, that is a search for context-free generalisations (Benson, 1982, p. 146)

The fifth political perspective, the symbolic implementation perspective, is the least developed and least mapped organisational perspective (Bolman & Deal, 1984) and could be subdivided into (1) the symbolic

decision perspective; and (2) the symbolic action perspective.

The symbolic decision perspective suggests that decision-makers and policy-makers in particular do not intend that all decisions be implemented (Hill, 1982; Beyer et al, 1983; Hunter, 1983; Barrett & Hill, 1984; Korman & Glennerster, 1985). Some decisions would be enacted only as a ceremonial (Trice et al, 1969) reflecting the electorate's mood of the day regarding the particular issues. Others would be empty promises designed to cool down strong opposition from various interest groups (Beyer et al, 1983). According to Barrett & Hill (1984), the persistence in attempting to implement a policy at what transpires as the wrong level could also be interpreted as essentially symbolic. It may be attributed to a reluctance to attack the real interests which would be more appropriate targets. As Korman & Glennerster (1985) indicated:

"the reason why some policies are not implemented is that no one ever expected them to be. Acts are passed or ministerial speeches made to satisfy some party pressure or awkward interest group but civil servants know that they need not strain themselves too hard to achieve results. The policy is symbolic." (p.7)

When the results are not forthcoming while external pressure increases or if crisis occurs,

unavoidable bureaucratic dysfunctions will usually be diagnosed and the management blamed. Pfeffer & Salancik (1978) have labelled that scapegoating process the "symbolic role of management":

"The manager is a symbol of the organization and its success or failure, a scapegoat, and a symbol of personal or individual control over social actions and outcomes. The symbolic role of management derives in part from a belief in personal causation as opposed to environmental determinism ... As a symbol of control and personal causation, managers and organizational leaders can be used as scapegoats, rewarded when things go well and fired when they go poorly ... When problems emerge, the solution is simple and easy - replace the manager" (p.263)

The symbolic decision perspective offers a somewhat Machiavellian account of the policy formulation/implementation processes which, nevertheless, could sharply strike the policy observer's imagination. As Barrett & Hill (1984) indicated from an essentially symbolic standpoint, the study of implementation would not be of much interest, except to demonstrate how people are duped. Besides, it draws a picture of decision-making which gives total control to the central decision-makers at the expense of the peripheral implementers. The research has shown that the peripheral implementers are not powerless in fixing the outcomes of the decision process (Pressman & Wildavsky, 1973; Hunter, 1980, 1983; Hardy, 1985). Aside from limited anecdotal accounts, there are very

few extensive empirical studies widely supportive of this symbolic view of implementation.

The Symbolic Action Perspective extends the Symbolic Decision Perspective and thereby provides a perspective which is of much use for studying implementation processes. This perspective emphasises the role of political language and symbols in implementing decisions. As Pfeffer (1981) pointed out,

"Political language and symbolic action can have consequences for mobilization and motivation of support, for cooling off or placating opposition either inside or outside the organisation, and for organizing activity within the organization around the issue of implementation" (Pfeffer, 1981, p. 211)

This perspective combines ideas about sources, uses, and outcomes of power together with ideas concerning the role of symbolism, language, beliefs, and myths. The argument is that considerations of power and influence are relevant for predicting resource allocations and strategic choices, while consideration of language and symbolism are critical to understanding the process designed to create legitimacy for these outcomes of power. Pettigrew (1977, 1979, 1985) has championed such a unified view of political and cultural analysis of organisational activity, which he refers to as the Political and Cultural Perspective on Organisational Process.

"The political-cultural view of organisational functioning gives emphasis to the propensity of actors and groups in organisations to create and maintain systems of meaning and to articulate broad interpretative schemes, values, and interests" (Pettigrew, 1985, p. 136)

In short, it is suggested that organisations are systems of patterned activity in which the various actors attempt to develop and convince others of the dominating legitimacy of their actions, ideas, and demands. These actions and decisions become legitimate when the various actors accept them because they believe that they are sufficiently just and right for willing compliance.

"If outcomes can be legitimised to the point where they are not questioned, even by potential opponents, actors have succeeded in obtaining their desired outcomes by using their power to prevent conflict from arising ... This aspect of power has been termed unobtrusive (Hardy, 1985), not so much because power is used unobtrusively but because of the circumstances in which it is used and the objective of its use. Overt power is employed in situation of overt confrontation, with the aim of defeating opposition. Unobtrusive power is used before overt confrontation occurs, with the explicit aim of preventing it " (Pettigrew, 1986, p. 135)

The key element to successful implementation is the use of language, symbols, beliefs, myths, rituals, ceremonies and settings in presenting the decisions so that a social consensus around them emerge. Yet, political language and symbolic activity take place in

a competitive environment. Both sides of the political contest seek to manage the process by which actions and events are given meaning.

"The management of meaning refers to a process of symbol construction and value use designed both to create legitimacy for one's actions, ideas and demands, and to delegitimise the demands of one's opponents" (Pettigrew, 1985, p. 44).

The task of those who resist implementation is to discredit the symbols and language used by those who promote the implementation, to make people aware of grievances, to politicise issues, and to delegitimise the actions, ideas and demands of their opponents. This would be achieved most often in an incremental rather than a rational-linear fashion.

The proponents of this perspective such as Pettigrew (1979, 1985), Pfeffer (1981, 1982), Hardy (1985) have distinguished between the substantive outcome and the sentiment outcome of political activity. The former depends largely on scarce resource control and dependency considerations while the latter is mainly influenced by the use of political language and symbols.

Success of implementation could be expressed, not solely in terms of achievement of objective or in terms of variation from original intentions, but also in terms of feeling of appropriateness, justice and

legitimacy of four main elements: (1) the proposal itself; (2) the mechanisms and the procedures used to meet general assent - or to avoid provoking public dissent; (3) the speed of implementation; and (4) the anticipated side-effects of implementation. According to Hardy and Pettigrew (1985) and Pettigrew (1986), political actors may also define success as the ability to establish areas of influence where dominating legitimacy is established and thus unchallenged.

The main contribution of this perspective has been to highlight the critical role played by political language and symbols in arousing support, quieting opposition and justifying the aims and power position of the various participants. Another significant contribution of this perspective has been to treat the implementation of strategic changes as a long term process, incorporating the antecedent conditions, political and cultural forces within the organisation, and the wider social, economic, and competitive forces with which the organisation must operate. An additional major contribution has been to empirically demonstrate that power could not only be used to produce preferred outcomes in the face of conflict but also to ensure that conflict does not occur in the first place.

As Pettigrew (1987) recently indicated, there is still much to be done to develop a perspective which combines political and cultural elements to analyse change processes and which focuses on the interconnections between the context, the content, and the process of change. Research at this level is not yet common.

The main strength of the political approach is its powerful descriptive validity. It points to the central importance of conflict and political processes in organisation and decision. Furthermore, it presents a useful realistic portrayal of implementation which captures a number of significant organisational dynamics such as legitimation and coalition building processes which are overlooked in other approaches. As Bolman & Deal (1984) recently indicated,

"The political perspective is an important antidote to the antiseptic rationality that sometimes characterizes rational perspective and the naive optimism that is sometimes present in human resource theories" (p. 216).

However, the political approach has been subject to challenge on a number of points.

"Critics describe two major limitation in the (political) frame: (1) The political perspective is so thoroughly focused on politics that it underestimates the significance of both rational and collaborative processes. (2) The frame is normatively cynical and pessimistic. It overstates the inevitability of conflict and understates the potential for effectiveness

and collaboration" (Bolman & Deal, 1984, p. 144).

The research which substantiates the political approach has been criticised for relying primarily on "soft" methodologies such as historical analysis and case studies. As Pettigrew (1985) indicated, as with so many other areas in the social sciences the empirical findings and theoretical developments in the field of organisational change are method-bound. It has been argued that the research findings lack generalisability and that the research provided little advice to managers on how to predict implementation problems as well as on how to improve implementation processes (Elmore, 1980; Starkey, 1987).

These criticisms are common arguments in the debate between hard and soft research methodologies. The political approach to implementation is not unlike other areas of social sciences which are also relying primarily on case studies and historical analysis in developing knowledge. By delving more deeply into organisational life, the methodology has provided the investigators with meaningful insights concerning the intangible aspect of political processes (Pettigrew 1973, 1985; Mintzberg, 1979; VanMaanen, 1979).

The obvious point to make here is that political perspectives are no panacea. Not all decisions are equally political or are equally likely to be affected

by the power of the organisational participants involved: Some decisions would be more political than others (Hickson et al, 1985). Therefore, the political approach may be more analytically valuable in some kinds of organisation and decision than others.

"Political theorists have made a strong case for the proposition that power and politics cannot be ignored in organisation theory, but they have not yet investigated in detail the complex interplay among rationality, human needs, and politics ... To say that organisations are political is true but too easy. What is needed is more differentiated propositions about variables influencing political processes in organisations" (Bolman & Deal, 1984, p. 217).

Review of the Literature: Summary and Discussion

There are a number of important points derived from the preceding literature. The first is that the conventional claims that too little attention has been paid to the question of implementation (Pressman & Wildavsky, 1973) or that little is known about it (Van Meter & Van Horn, 1975; Williams, 1976; Voger, 1986) are no longer grounded. The volume of literature dealing with implementation issues is now enormous.

The second point is a related although significantly distinct issue emerging from the review. It concerns the pluralism of the literature on implementation. This chapter features the interdisciplinary diversity of the literature and provides a comprehensive review of the recent

theoretical work on implementation in organisation theory , public policies and in political science. Seventeen differing perspectives grouped into four distinct categories have been briefly outlined together with their main advantages and limitations.

Why has such a diversity of theoretical perspectives occurred? Nakamara & Smallwood (1980) and Bourgeois & Brodwin (1984), among others, have suggested that the different models of implementation represent a trend towards increasing sophistication in thinking about implementation, revealing a progressive shift away from the classical approach. The diversity of perspectives would result from the perceived failure and limitations of the already existing perspectives leading gradually towards the development of more refined alternative perspectives.

There are a number of problems with this attempt to explain the diversity of perspectives. First, the building up process of increasing sophistication should logically direct towards one single best and, therefore, generally accepted model of implementation. An essential conclusion of this review of the literature is that, as yet, there is no such analytical consensus; neither on the most meaningful approach for examining implementation nor on what factors are the most important to consider.

Second, such an explanation for the diversity of perspective implies that there is a rough chronological trend in the development of the perspectives available, beginning with the classical approach followed by the contingency approach ensued by the behavioural approach and ending with the political approach. The roots of these differing approaches can be found in the development of the theory of public and business administration which is often portrayed in such a contextual sequential linear fashion. It was, however, only during the 1970s that the "implementation gap" was finally recognised as an important issue, initially in the USA (Nakamura and Smallwood, 1980), and then in the UK (Hunter, 1983). As Nakamura & Smallwood (1980) indicated,

"During the 1970s a growing number of publications appeared in an attempt to pin down what Erwin C. Hangrove has called the Missing Link in social policy - the implementation process. Although earlier papers, articles, and books had commented on selective aspects of what we now label Implementation Studies, it was not until 1973 that such studies assumed major visibility with the Pressman and Wildavsky's book Implementation" (p. 12)

Our literature review portrays a concurrent as opposed to a sequential linear development of the perspectives on implementation. Table 2-0 enumerates some of the leading scholars who, during the 1980s, have been contributing concurrently to the literature.

Third, this evolutionary explanation for the diversity of perspectives implies that there should be a diminishing support for the classical approach. Our review of the literature does not indicate a decline in the popularity of the classical perspectives. To the contrary, the classical approach is still prevailing in both sets of literature, public policy and strategic implementation (Gray and Hunter, 1983; Hardy, 1986).

The literature review undertaken in this chapter suggests a more satisfactory explanation for the diversity of the perspectives on implementation. There are three main reasons for the variety of perspectives. First, there is enough evidence in the literature review to support the view that there are multiple processes concurrently at work in implementation. These processes involve, at the same time, a number of analytical, structural, behavioural, and political dimensions. Each perspective emphasises a limited aspect of implementation. The number of perspectives is partly accounted for by the diversity of processes at work and by the complexity of the issue investigated.

Second, being a relatively new area of inquiry, implementation borrows concepts and research methods from already established, related disciplines. For example, the "unfreezing-moving-refreezing" change

sequence proposed by the the psychologist Lewin has had an influential impact on some of the behavioural perspectives, whereas the concept of "fit" (Venkatraman and Camillus, 1984, p. 513) has served as a central thrust to the development of the contingency approach. The diversity of perspectives reflects the skill and the variety of the conceptual frames of reference of the social scientists who, in the 1970s and in the 1980s, have entered the field attempting to explain the implementation process and outcome. As Allison (1971), Elmore (1978), Barrett and Fudge (1981), and Pettigrew (1987), among others, have suggested, what we see depends on where we are and which way we are looking.

"Where we sit not only influences where we stand, but also what we see. Few social scientists would claim to enter the field with empty minds waiting to be gradually filled by evidence" (Pettigrew, 1987, p.649).

In the twenty years in which the field has truly been in existence the issue has attracted people from several disciplines, including sociology, social psychology, political science, and organisation theory. This suggests that implementation is a highly complex field involving many substantive issues. As Scheirer (1981) pointed out,

"Each social science discipline seems to have one or more strands of theory addressing problems of social change, but thus far no synthesis has emerged which weaves together these diverse threads of discourse" (p.24)

Each of the theoretical approaches and their perspectives to implementation has focused on one set of variables as the key to successful implementation.

Third, the diversity of perspectives occurred also as a result of the variety of contexts as well as the wide span of disparate contents areas which have been considered by the various scholars. The literature on implementation contains works ranging from the study of the failure to produce jobs for the hard-core unemployed in Oakland (Pressman & Wildavsky, 1973) to the successful implementation of a diversification strategy in a medium-size computer company (Voyer, 1986). As Lowi (1964), Van Meter and Van Horn (1975), and Grindle (1980), among others, have already pointed out, the implementation process and outcome vary depending on the content of public policy and the context of administrative action.

"Clearly, then, the content of public programs and policies is an important factor in determining the outcome of implementation initiatives ... policy or program content is often a critical factor because of the real or potential impact it may have on a given social, political, and economic setting. Therefore, it is necessary to consider the context or environment in which administrative action is pursued" (Grindle, 1980, p.10)

There is one further essential point deriving from the literature review undertaken in this chapter. There

is no single or correct general theory of implementation. Instead, there are a large number of competing perspectives favouring a limited number of factors in explaining implementation phenomenon. The focus on one group of factors alone, the tendency to overlook the contexts, and the neglect of the processes surrounding implementation, have caused the literature to become diffuse and inconclusive. Because of these shortcomings the research has not been able yet to dismiss the conventional top-down chain model in which directives from above are expected to be fully implemented at once by front-line operators.

To make further progress towards an understanding of implementation it is now necessary to incorporate these factors into a more unified and holistic framework, to bring in an appreciation of the contexts, and to study the dynamic of implementation processes over time. This would allow the research to address the variety and complexity of implementation in detail, increasing the explanatory power and the value of the approach as a guide to action.

Such an eclectic and integrative approach is now possible by building on the contextualist theory of method developed by Pettigrew (1985, 1987, 1988, 1990) and used by the various members of the Centre for

Corporate Strategy and Change (CCSC), University of Warwick.

"The analytical cornerstone of the CCSC research is the view that theoretically sound and practically useful research on change should explore the contexts, content, and process of change, together with their inter-connections through time. The focus is on changing, catching reality in flight; and in studying long-term processes in their contexts, a return to embeddedness as a principal of method" (Pettigrew, 1990, p. 3)

Contextualism offers at least two major theoretical and methodological advances important to the study of implementation. First, it allows simultaneous consideration of the many key internal and external factors likely to influence the implementation process and outcome. A contextualist analysis of implementation draws on phenomena at horizontal and vertical levels of analysis and the inter-connections between those levels through time. For example, the lack of resistance of the GPs to the closure of their GPMU should not be solely associated horizontally with the decreasing opportunities to maintain their skills resulting from the diminishing number of maternity beds over the years. It must also be linked vertically to national medical, technological, clinical, and socio-economical change over that same period of time. Such an holistic explanation for the GPs behaviour trades simplicity for realism. Causation is neither linear

nor singular. Implementation phenomenon have multiple causes and are to be explained more by the convergent interactions and interconnected loops among factors and features over time. The result is a holistic account of implementation in which content and context are repeatedly reviewed alongside process variables.

Second, contextualism provides an approach capable of drawing on concepts from a variety of disciplines. This literature review has featured the interdisciplinarity of implementation. It has been suggested that there are multiple processes concurrently at work involving rational, structural, behavioural, and political dimensions. Implementation is a complex phenomenon which could benefit from a holistic treatment allowing distinct paradigmatic approaches to co-exist and contribute to the analysis of what is happening. Chapter three presents the contextualist framework.

CHAPTER THREE

Studying The Implementation of Closure Using a Contextualist Framework

This chapter outlines the contextualist research framework and specifies its components for studying the implementation of closure of GPMUs. It reviews the research literature on the implementation of closure in the NHS and enumerates the main questions that will be dealt with in this study.

The Contextualist Framework

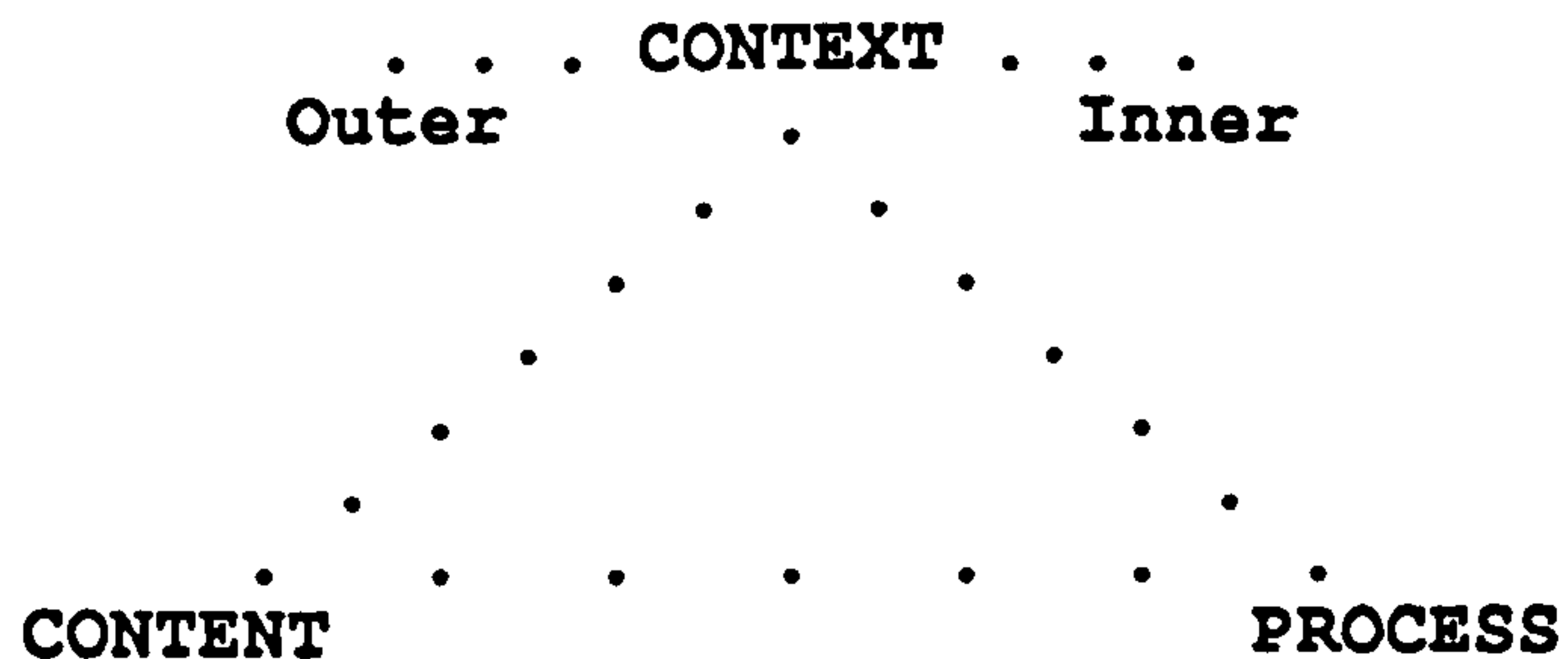
The contextualist framework emphasises the inter-play between three different groups of factors: (1) the contexts of change, (2) the process of change, and (3) the content of change, together with skills regulating the relations between the three. According to Pettigrew et al (1988),

"The what of change is encapsulated under the label content, much of the why of change is derived from an analysis of inner and outer context, and the how of change can be understood from an analysis of the process" (p.301).

An outline of the CCSC analytical framework is presented in Figure 3-0 and the major components of each group of factors are listed below.

Figure 3-0

Outline of the CCSC Framework for
Studying Strategic Change



CONTEXTS

OUTER

Political economy
National Policy and finance
Changing patterns of
mortality and morbidity
Social movements
Population shifts

INNER

Formal Organisation
History
Local policy and finance
Culture
Power Relations

CONTENT

Acute vs priority group
Growth vs retrenchment

Radical vs Incremental
Top down vs bottom up
Technological vs social
Predictable vs risky

PROCESS

Action and interaction
Product champions
Dominant coalitions

Perceptions
Assumptions and roles
Legitimisation

Source: Pettigrew et al (1990).

Although the analytical separation of these three clusters of factors may make them appear to be structural entities, the contextualist model is designed to be understood as composed of dynamic processes with mutually contingent inter-relationships over time. No single component of the model is expected to account for the success or failure of implementation. Focusing on one or the other of these three categories of factors as the key to understanding implementation is bound to promote neglect of the other levels that are equally vital influences on implementation outcome.

The content refers to the particular area of transformation under study. Various aspects of the content might have an impact on the kind of activity stimulated by the implementation process. For instance, Van Meter and Van Horn (1975) argued that the implementation process varies depending on two key characteristics: (1) the amount of change involved and (2) the extent to which there is goal consensus among the participants. Grindle (1980) also indicated some features of content affecting the implementation of a proposal. He suggested that an implementation gap is more likely to be found when the benefits provided by the proposal are divisible than when collective benefits are realised. Change that is designed to

achieve long-range objectives, which requires considerable behavioural adaptation, and that depends upon a network of widely dispersed decision units would be far more difficult and onerous to implement than change whose advantages are immediately apparent, change depending on a small number of key powerful decision units, and change requiring little in the way of changed behaviour patterns. In addition, the form in which goals are stated may also have a decided impact on implementation. Whether they are stated clearly or ambiguously and whether the key actors are in agreement about them can be decisive for the implementation, especially at the local level. Pettigrew et al (1988) suggested that the speed, the quantity, the quality, and the consequence of the proposal being implemented on the receptivity of the context to future change are also important features of content. Some changes will be radical, others incremental. Some changes will involve contraction, others development. The degree of uncertainty, of risk and the availability of models from which cues can be taken can also be important.

Clearly, then, various features of the content can have a significant impact on the process and outcome of implementation initiatives. This research is primarily concerned with a single change issue: the permanent

closure of GPMUs. Therefore, the content level offers several important similarities between the cases; major differences relate to the contexts and process levels.

As Wildavsky (1979) pointed out, "the context controls (or at least heavily conditions) the implementation" (p.164). One of the major contentions of this research is that proposals similar in content may still be implemented differently if the context in which they are pursued differs substantially.

Analytically the context of implementation is divided into outer and inner context. The outer context refers to the global environmental dimensions which influence concurrently on all the DHAs at a given time. Usually, these dimensions are not within the direct control of the districts albeit part of the managerial action could be to amplify some of them in order to develop concern and to legitimate the content of change.

Building on the CCSC conceptual framework, the outer context might include a number of dimensions such as the DHSS policy and the RHA strategy for maternity services, the DHSS formal procedures and guidelines for closure, the National trends in the birthrate and in the perinatal mortality ratios, the changing role of the professional and the technological development in obstetrics, the social and ideological movements

regarding the medicalisation of childbirth and the place of birth, the major structural and ideological changes in the management of the NHS, such as the 1982 reorganisation and the implementation of general management.

The outer context could also include a set of local features which could impinge on the process and outcome of implementation. These encompass various dimensions such as the history and state of formal and informal relationships between the local CHC and the DHA, the political tradition of the locality and the status of the health services in the local political agenda, the geography of the district and the competing centres of population, the social fabric of the local community and the network of powerful local groups.

By contrast, the inner context refers to the characteristics of the district itself. It comprises various features such as the size of the district, the district strategy for maternity services and its place in the strategic and operational change agenda, the history of the issue in the district and the skill of the key district managers, the district leadership and the championing of the closure proposal, the profile of the unit involved, the professional support for the GPMU. These factors and features of the district set the scene for implementation, but part of the action

could aim at securing change to the inner context itself in order to set more receptive conditions for implementation. A major contention of the research developed in this dissertation is that both the local outer context and the inner context have a critical impact on the genesis, development, and conclusion of GPMU closure decisions.

One of the main pillars of the CCSC framework is its processual approach. It avoids the trap of concentrating either on decision-making, structure, people, or power at the expense of how the process itself is managed through time. In the present research the process refers to the path of actions, reactions, and interactions of the various interested parties involved in promoting or resisting the closure of a particular GPMU.

Critical at that level of analysis are the attempts by the proponents and by their opponents to redefine the issue, the types of action that are regarded as legitimate by each side in contest, and the process used by the protagonists to create legitimacy for their demands and to de-legitimise the demands of others, which Pettigrew (1977, 1979, 1985) refers to as the "management of meaning"

"The management of meaning refers to a process of symbol construction and value use designed both to create legitimacy for one's actions, ideas and demands, and to

delegitimise the demands of one's opponents. Key concepts for analysing these processes of legitimisation and de-legitimisation are symbolism, language, belief, and myth" (Pettigrew, 1985, p.44)

Several analysts have stressed the benefit of examining processes in a number of stages or sub-processes (Quinn, 1980; Berman, 1980; Scheirer, 1981; Kanter 1983). This segmentation of the implementation processes can be useful particularly for translating descriptive processes of change into prescriptive analytical statements about the various managerial tasks, constraints and challenges at each of the stages in creating strategic change (Pettigrew, 1985).

Analytically, the process is here conceptualised as three interdependent and overlapping sub-processes: (1) the genesis of the closure proposal, (2) the development of the action, and (3) its conclusion. These three major stages form the skeleton of our analytical chronologies of the proposal to close the maternity units contained in chapters six to nine.

The three groups of factors for studying implementation have now been presented. A central thesis of the contextualist longitudinal research design is that implementation ultimately involves a whole set of factors, features, and processes in interaction over time. The overall challenge of this type of research is to connect up the context, content,

and process levels of analysis in developing a holistic explanation for the success and failure of implementation.

While the study performed in this dissertation and the CCSC study share the same basic framework, there are a number of differences between them including the literatures which they are based upon and the research sites. The critical difference lies, however, in the type of service change investigated. The CCSC study addresses the implementation of a number of current major strategic service changes. Their study is designed so as to analyse how management tackles a large interrelated change agenda, juggling time, energy and political capital between strategic issues. The research reported in this dissertation is less extensive and ambitious than the CCSC's study. It has a single change issue: the closure of the peripheral GPMUs. The issue offers an attractive opportunity for studying the dynamics of implementing at DHA level.

The Implementation of Closure in the NHS

What has the existing research literature on closure in the NHS to say about either the content, the context, or the process of implementation? There is only a handful of academic research on the implementation of closure in the NHS. These include: the study of the closure of two small hospitals

focusing on the impact of the process of consultation by Korman and Simons (1978); the study of the delay and change of pace in implementing the closure of a large institution for mentally handicapped people by Korman and Glennerster (1985, 1990); the research on the managerial strategies and different responses to closure of two small hospitals and two factories by Hardy (1985); and the study of the differences between authorities closing two psychiatric hospitals by Tomlinson (1988). Other research has investigated the effects of run-down and closure, together with the build-up of alternative services, particularly for mentally ill people (Bennett, 1989; Wing 1990, 1991; Leff, 1991).

The CCSC series on the management of change in the NHS also includes two groups of closures: two acute hospitals and two psychiatric hospitals (Pettigrew et al, 1990). Because in many respects the present research is similar, indeed indebted to this pioneering work, it may be useful at this point to review these researches in turn and to point out the key findings that are particularly relevant to this dissertation.

Korman and Simons (1978)

Korman and Simons (1978) studied two decision-making processes of hospital closures during the period 1972 to 1976. The research was one of four similar

studies on various issues commanded by the Royal Commission on the NHS. The aims of their research were to describe the process of closure and to illustrate how consultation was perceived and practiced by those involved. The study took place within one single region and the two cases were selected because they illustrate, respectively, high and low opposition to closure. Much of the data were taken from written sources complemented by informal discussions with some of the key participants.

Korman and Simon (1978) found that although the proposals to close both hospitals were clearly decisions by management, the officers did not always have control over events concerning closure. A number of external factors such as the 1974 reorganisation, the Labour government return to power in February 1974, as well as the autonomous actions of the clinicians and their Councils, impinged on the implementation of the closure proposals. They also pointed out that the community access to alternative facilities, the ways the proposed closures were announced, particularly to the staff, and the managerial policies of consultation were important factors in explaining the different pace of implementation and the strength of the opposition to the closure proposals investigated.

Korman and Simons (1978) finally indicated that, in addition to seeking advice from others, consultation can serve different purposes such as protection of group interests, information, negotiation, maintaining working relations, and reviewing the reasoning process of the decision. The variety of purposes reflects both the ambiguity of the concept of consultation and the varied expectations brought to the process by the various interest groups being consulted. They concluded that consultation may at time cause delay in implementation but it can also increase the legitimacy of a decision and , therefore, ease its implementation.

Korman and Simons' research is interesting in comparison with the research reported in the present dissertation, particularly because it lists some of the contextual features which, although beyond managerial control, added pressure and influenced the timing and the pace of implementation. There is, however, little analysis in their study beyond that point. The processes and mechanisms through which these features worked are neither specified, illustrated, nor explained. Furthermore, the researchers do not place their empirical material in a broader frame of reference. The processes and events involved in both hospital closures are presented solely in the form of a diary and there is no attempt to focus on analytic

abstractions for purposes of presenting theory at some level or another. The study does not take into account the evolution of the idea and action for closure as well as the constraints within which the decision makers operate. Little attention is paid to the immediate and more distant antecedent conditions of the implementation episode considered. An undoubted weakness of the research is that it neglects almost entirely the inner context of the health authorities responsible for the closures.

Korman and Glennerster (1985,1990)

Korman and Glennerster (1985,1990) present a detailed case-study of the long and complex process of the first closure of a large institution for the mentally handicapped in Britain: the Darenth Park Hospital in London. The research was commissioned by the DHSS at the request of the hospital Steering Group. The resettlement of residents outside the hospital was also evaluated (Wing, 1990; Wing 1991). An interim report was produced in 1985 (Korman and Glennerster, 1985) but their book published in 1990 covers the entire closure programme. The study relied on a variety of sources of information such as files, informal conversations, interviews, attendance at meetings, and feed-back reports.

Korman and Glennerster (1990) found two phases in the process of closure of the hospital. The first phase began in 1970 and ended in 1983. It is described as "a long and frustrating period of planning, much of which proved abortive" (Korman and Glennerster, 1990, p.1). During the second phase, events moved rapidly and the hospital finally closed in August 1988.

Korman and Glennerster (1990) set the closure in the context of the theoretical debates about de-institutionalisation and normalisation. They argue that the precipitating factors which made the closure a feasible option were numerous but that the ideological pressure behind normalisation proved an important factor. They also put the closure in the national policy and financial context. In particular, they illustrated how the critical change in the financial ground rules resulting from the DHSS green paper on financing priority group services (DHSS, 1981) had a significant impact on both the change of pace of implementation and on the outcome of the closure proposal. According to the authors this shows clearly that public bureaucracies need an appropriate incentive structure to respond to national policy. The introduction of general management and the inception of the accountability review system are pointed out as

important contributory factors in speeding up the process of closure.

Before 1983, the philosophy and actions of the regional officers conformed to the classical, rational, central planning approach. On the basis of the evidence provided in the case-study, Korman and Glennerster (1990) argue that the assumptions of this approach are naive. The divergent interests within and between the various interest groups involved, the divergent models of care between the Region and the local authorities, the cut back of financial support given by the central government to the local authorities after the 1976 economic crisis, and in general the lack of incentives for cooperation or effective sanctions to obtain compliance, all are shown to have contributed to slowing down the centrally planned process of closure during its first phase of implementation.

Continuing pressure to succeed from the regional officers and important changes in their approach to implementation were critical to the success of implementation. This stressed the key role of higher tiers, in this case the RHA, in driving through change. The new approach combined central pressure with the freedom of the district to produce its own solutions

and generated a more rapid pace of change during the second phase of the closure.

"What emerged after 1983 was a new pattern of strong regional leadership with professional and technical support for those undertaking the reprovision locally, but with a maximum amount of financial devolution and minimal detailed capital control. That approach conforms well to the pattern of management exercised in some of the most successful large corporations, if we are to believe Peter and Waterman (1982), a tight-loose relationship between the centre and the district and unit level managers" (Korman and Glennerster, 1990, p.158).

According to Korman and Glennerster (1990) the changing approach to closure illustrates that public servants can be innovative and that public bureaucracies can adapt and can learn from their mistakes.

Korman and Glennerster's research is clearly "contextualist in character" (Pettigrew, 1990, p.5); it offers both a multi-level and a processual analysis of the pace and success of the implementation process of the closure at local level. The contribution of the research is, however, limited not so much because it has a single change issue focus but because it is based on a single case-study. The research does not allow the analysts to demonstrate how variability in context influenced variability in process and outcome.

Hardy (1985)

Hardy (1985) provided a thorough comparative case-study research of organisational closure using a contextualist framework. Her study is similar to that presented in this dissertation in terms of investigating the management of closure at DHA level. The study focused on the response to the closure proposals using the concept of unobstrusive power:

"The essence of the unobstrusive aspect of power is the ability to give meaning to events and actions, and to influence the perceptions of others so they either remain unaware of the implications of political outcomes or view them in a favourable way. Unobstrusive power is thus founded in the ability to define reality, not only for oneself, but for others" (p.47)

Hardy's book contains four case-studies: the successful closure of two factories and one hospital as well as the failure to close a maternity hospital during the period 1975 to 1979. Unfortunately, she did not undertake to discuss either the reasons behind the selection of her cases or the justification for combining together factories and hospitals closures in her research. She did not look particularly at commonalities and differences across public and private organisational contexts. It is left to the reader to assume that this selection of cases was justified. The cornerstone of her methodology was the use of informal interviews. This was supplemented with evidence from

written and documentary sources and the use of various unobtrusive measures.

Hardy's study aimed at explaining why different responses to announcements should arise, and why some closure decisions are implemented without opposition, whereas others are confronted with resistance. The research focused primarily on the employees and the Trade Unions' responses to closure.

Hardy found that the economic difficulties which prevailed in Britain from 1974 to 1980 led to increasing numbers of closures but that the employees' resistance to closure died away over time. She argued that the social legitimacy of closure has changed during that period. The accumulation and continual justification of closure on economic, technical and commercial criteria has rendered closure more acceptable and, therefore, less resisted. The general decline in the power of Trade Unions also accounts for the diminishing trend in the action against closure.

The specific organisational context of the closures also was significant, particularly in contributing to the power resources of the different interest groups involved. The important factors and features specified by Hardy (1985) at that level of analysis include the rate of unionised workforce, the support from other unions, the wider support from the

media and the public, the strategic leverage, the organisational culture, and the characteristics of the workforce such as the age of the staff.

Hardy's analysis of the case-studies indicates that, apart from any contextual influences, the specific reaction to the closure proposals investigated depended on the managerial strategies for closure. She was able to identify four key strategies used by managers to reduce the possibility of resistance: (1) the creation of managerial credibility via climate-setting or tactical opportunism; (2) the consultation with employees, unions, and other groups; (3) the provision of redundancy payments for lost jobs and redeployment arrangements; and (4) the justification of the closure on the basis of acceptable criteria.

Hardy concluded that no explanation for the resistance to closure is complete without reference to each of the three elements of her framework: the wider environment, the organisational context and the managerial process. She also stressed that managers do try to define proposals in such a way as to secure favourable sentiments towards the closure among potential opposition groups.

Hardy's study of the different responses to closure provides a good example of a contextualist research. It illustrates how the employees' response

to closure has changed over time as a result of the accumulation of the continual justification of closure particularly on economic grounds by companies struggling against a declining economy. An interesting contribution of Hardy's (1985) study is that it illustrates the critical impact of managerial action on the outcome of the individual closure proposal.

Although the focus of the research on the Trade Unions and employees' reaction to closure permits the combination of commercial firms and public agencies in the research sample, it does not present a realistic picture of the complexity of the response to closure in the NHS. To Hardy's credit her case-studies deal to a limited extent with the medical staff as well as with the Community Health Council (CHC) response to the closure of the hospitals investigated. She clearly overlooks, however, the historical, cultural, and institutional form of the hospitals concerned, the history of previous attempts to close the facilities, as well as the policy context and the administrative politics of closure of services in a large and complex public bureaucracy as the NHS.

Tomlinson (1988)

Tomlinson (1988) examined the North East Thames RHA's (NETRHA) decision, made in 1983, to close and re-provide two hospitals, Friern and Claybury, out of the

six psychiatric hospitals in the region. The research was conducted by the RHA mental health research committee seeking for lessons that could be learned for other closures. A cost effectiveness analysis of the closures was also undertaken (Leff, 1991).

Tomlinson (1988) noticed wide differences between both health and local authorities in the overt influence of members over decision-making as well as in the role of the chairmen. He argued that these differences indicate the possibility of identifying a number of types of authority. Drawing on public policy making literature, he constructed a set of archetypes of implementing authority ranging along a continuum of discretion in developing and implementing independent strategies from central government. Those at one end of the continuum, the "Athenian Authorities" (p. 188), can develop discrete policies, change their organisational structure to implement them, and regard legislative limits as open to interpretation. Those at the other end of the continuum, the "Controlled Authorities" (p.185), have little ability to pursue courses of action autonomously from the direction and very limited choices for change to administrative structure. In the middle of the continuum, the "Autharchic Authority" (p.186), can develop discretionary policy as market demands arise and change

structure to fulfil such policy within legislative limits. According to Tomlinson (1988) the two DHAs responsible for implementing the closure of the hospitals belong to the "Autharchic" type.

He pointed out that a number of features of the change content such as the relatively low status of Mentally Infirm services in the local change agenda, the complexity to achieve staff redeployment and retraining, and the problem of re-providing the services, call in RHA's intervention. He concluded that the feasibility and the likely outcomes of these interventions, closing down or opening up opportunities for discretionary decision-making, can be considered in the light of the archetype of authorities having responsibility for the implementation.

Tomlinson's (1988) main contribution has been to suggest that public authorities with differentiated degrees of autonomy in formulating and implementing strategies can respond differently to the same centrally pronounced policy and to list some of the features of content that influence the process of implementation. The research presents, however, some major logical inconsistencies as well as a number of critical methodological and analytical shortcomings.

First, there is a definite disjunction between the empirical evidence reported and the findings of the

research. The case-study narrates in some length the history of the NETRHA decision to go ahead with the closure of the hospitals but it does not provide evidence on the response of the various health and local authorities with responsibility for its implementation. The archetypes of "implementing authority" are, therefore, entirely theoretical and not empirically determined. There is no evidence of a logical connection between his archetypes of implementing authorities and their response to the central policy.

Second, Tomlinson (1988) claims that wide differences were apparent from observation of Health Authority meetings and that these differences indicate the possibility of identifying a number of types of authority. He concluded, however, that the two DHAs responsible for managing the hospitals belong to the same archetype. Were the similarities more important than the differences then? He also claims that because the re-provision of the hospitals involves collaboration between health and local authorities "an essential part of the research has thus been to consider the response of local decision makers in both types of authority to the NETRHA initiative" (Tomlinson, 1988, p.184). The analysis fails, however, to connect back to the research material, which in any

case is not provided, and to mention which archetype the local authorities investigated belong to.

Third, and more importantly, the research is a typical example of ahistorical, aprocessual, and acontextual study of change. As Pettigrew (1985) pointed out:

"For as long as we continue to conduct research on change which is ahistorical, acontextual, and aprocessual, which continues to treat the change programme as the unit of analysis and regard change as an episode divorced from the immediate and more distant context in which it is embedded, then we will continue to develop inadequate descriptive theories of change which are illcomposed guides for action" (p.15).

Pettigrew et al, 1990

Probably the most extensive work carried out to date on the management of change in the NHS is the CCSC's research at the Warwick Business School, University of Warwick. The CCSC's series includes 8 cases-studies cutting across various strategic areas. The research was funded by the NHS Training Agency (NHSTA) and by a consortium of eight RHAs. The aims of the research were to identify the motors of, and the barriers to, change in a number of districts tackling concurrently many of the major strategic issues and to explore the skills associated with change management in the NHS. The study relies on three main sources: in-depth interviews, documentary and archive data, and

observational material. It includes four examples of closure: two acute hospitals, St Mary's Paddington and the Central Middlesex Hospital in Bloomsbury, and two psychiatric hospitals, the Rainhill and the Whittingham.

Pettigrew et al (1990) set their analysis of acute service rationalisation in the literature on organisational decline, death and the management of retrenchment. They illustrated that, in Paddington, the creation of the District in 1974 and the substantial change in thinking, from capital to service planning, speeded up the pace of change. They found that the combining of retrenchment and redevelopment was crucial to the whole process. The deliberate selection by the Chairman of a team of people offering complementary rational-analytic and political skills was also an important factor. The case illustrates the key role of the rational process, particularly in convincing sceptics, as well as the importance of the political skills of the leaders in securing sound central commitment, anticipating objections, making concessions, and building a dominant coalition with the clinicians (McKee, 1988). The ability of the team of people promoting the closure to learn from previous errors and to modify their approach also stands out as a critical factor. The reduction of complexity through

the use of flexible and locally based ad hoc groups and the development, at the start of the process, of a broad vision rather than detailed technical planning were further critical contributory factors to the success of the proposal.

The evidence shows that the pace of change has been slower in Bloombury than that in Paddington. One contextual explanation provided for this is the greater complexity in Bloombury: the district had twice the budget of Paddington, three post-graduate groups, a higher proportion of regional specialities and of cross boundary referrals. Above all, it included two teaching hospitals with independent traditions, a long history of rivalry, and pronounced cultural differences as well as a much wider range of conflicting and hostile interest groups than Paddington whilst no dominant coalition. Other contributory factors include: high dependency on developments in the academic sphere for success in service planning, a rapid management turnover at both senior and middle management levels and the loss of organisational memory, poor relation with clinicians, substandard manpower and information systems, a long history of poor performance and a series of financial crisis which diverted senior managerial time and attention. They suggest that the prospect of massive new capital

investment and the style and political skills of the new DGM have contributed to accelerate the pace of change in the late 1980s.

The CCSC series also includes an analysis of the ongoing process to close two large mental illness hospitals: the Rainhill Hospital expected to close by 1992 and the Whittingham Hospital planned to close by 1997. The analysis is set in the historical evolution of the asylums and the context of the present day national policy for psychiatric services based on community care and non-institutional therapies. The history and institutional characteristics of the institution are shown to have a persuasive influence on the management of change task.

Pettigrew et al (1990) indicated that although the context and content of each closure present many similarities in terms of the top-down pressures for change, key differences exist between the two projects in the clarity of the time scale and the scope of the regional strategy. Services for the mentally ill were a regional priority in the case of Rainhill but not in Whittingham. The latter had a longer term approach driven by incrementalist change as opposed to the more radical and expedient change featuring in Rainhill. They indicated that the appointment of a UGM in Rainhill speeded up further and sharpened up the

implementation process. The introduction of short general management contract and of performance review was also influential. The important differences in the process of change relate particularly to the language and style of efforts, with more emphasis at Rainhill on the language of opportunity and for action to dominate over legitimisation, whereas at Wittingham there was more emphasis on obstacles and on building a climate for change.

To date, March 1991, the CCSC book on managing strategic service change in the NHS has not yet been published. The Project Report (Pettigrew et al, 1990) which discusses the majority of the case-studies concludes that the management of change in the NHS is likely to be contextually very sensitive and that there is neither a quick fix, simple recipe nor universal way of implementing change in such a pluralist organisation. It suggests, however, looking at context in terms of its dynamic receptivity for change:

"We mean by the term receptive context that there are features of context (and also management action) that seem to be favourably associated with forward movement. On the other hand, there is in non receptive contexts a configuration of features which may be associated with blocks on change" (Pettigrew et al, 1990, p.118)

The list of key features associated with "receptive" context for change includes: the quality and coherence

of policies, the availability of key people; the intensity and scale of pressure; a supportive organisational culture; the relationship between managers, clinicians, and other professionals; a cooperative inter-organisational network; the simplicity and clarity of goals and priorities; and the fit between the district's change agenda and its locale.

The contribution of the CCSC's series on managing service change in the NHS is three-fold. First the study demonstrated the strength of the analytical approach lying in the combination of a contextual and processual view of implementation allied to a multi-level analysis. Second, it illustrated that the process of implementation demands longitudinal research which covers decades rather than years. Third, it provided comprehensive evidence from a number of major case-studies including four on closure.

Criticisms have already been made about the contextualist approach adopted by the CCSC researchers for studying the implementation of service changes in the NHS. Critics such as Starkey (1987), Clark and Starkey (1988), and Whittington (1989, 1990) have acknowledged the solid empiricism of the contextualist research but have expressed concern about its validity. They typically state that contextual research permits

the reconstruction of processes after the occurrences but does not allow for prediction of the future course of events; it brings forth lengthy descriptive histories which do not tell us very much about how to improve future performance in implementing organisational change.

This criticism can be questioned because it appears to be based on a limited view of organisational research on change which suggests that studies on implementation should only be concerned with issues which can directly improve the performance of organisations. In reply, it could be argued that detailed, comparative longitudinal research will lead to more complete understanding of the implementation of change. It could further be stressed that the research well suits the present state of knowledge in the implementation of change. Pettigrew (1987) has answered this criticism by stressing that:

"In uncharted areas of inquiry, description, analysis, and interpretation are laudable enough research objectives whilst amongst other things ought to allow us to contradict myths about rational problem solving processes of formulating and implementing change carried out by all-seeing and presumably omnipotent chief executives or general managers" (p. 425)

It does not seem justified to reject the contextualist research approach because it is primarily concerned

with descriptive as opposed to normative theory of change.

The second major criticism of the contextualist approach also relates to its validity. Critics argued that this type of research is limited because the case-studies developed by contextualist researchers are unique, based on too deep, detailed, idiosyncratic and emphatic understandings of the organisations investigated. The findings are, therefore, not generalisable beyond the immediate case or set of case-studies.

This criticism is also misdirected. The problem lies in the very notion of generalisation of findings. The critics are implicitly contrasting the findings of the longitudinal comparative contextualist research with those of survey research relying on statistical generalisation. The contextualist research relies, however, not on statistical but on analytical generalisation of organisational phenomenon based on a logic of replication in comparative settings. In analytical generalisation, "the investigator is striving to generalise a particular set of results to some broader theory" (p.44). To reject the contextualist approach because it is generating analytical as opposed to statistical generalisation, seems also unjustified.

Summary and The Key Research Questions

In summary, the proposed research framework directs attention to three clusters of factors: the content, the process, and the contexts - inner and outer. Each of these analytical dimensions can be a vital influence on the pace and fate of implementation.

The research literature reviewed in this chapter shows that important progress has been made since the first study on closure in the NHS was carried on twelve years ago. In particular, the field is slowly gathering momentum accumulating evidence from an increasing number of major case-studies. A promising framework to further our understanding of the implementation of closure within, as well as across, service area is now available. The existing work on closure in the NHS can be summarised in relation with the three analytical dimensions of the framework.

In terms of the content, there is as yet only a small amount of research available on the implementation of closure in the NHS. There has been, however, an emphasis on the closure and redevelopment of psychiatric services (Korman and Glennerster, 1985, 1990; Tomlinson, 1988; Pettigrew et al, 1990; Hall and Brockington, 1991) and a tendency to examine the issue at RHA level. Where there have been studies of Acute and Maternity facilities at district level, they

examine closure implemented before the 1982 reorganisation (Korman and Simons, 1978; Hardy, 1985) and, therefore, when the district authorities were not yet responsible for the closure of health services (see Chapter five). The CCSC series (Pettigrew et al, 1990) include two highly informative case-studies of recent closure of Acute facilities at DHA level but none of Maternity services. It is this forgotten area of services which is investigated in the present dissertation.

In terms of the process dimension of the framework, the researchers have put a critical focus on structure (Korman and Simons, 1978; Korman and Glennerster, 1985, 1990; Tomlinson, 1988) rather than action. Hardy (1985) and Pettigrew et al (1990) have, however, provided evidence that the way closure proposals are generated and the process of creating legitimacy for the proposal are most influential. They also argued that the research needs to take into account the historical evolution of ideas and actions for change as well as the constraints within which decision makers operate.

Finally, in terms of the context, the research literature reviewed in the previous section shows that, although some research has been acontextual (Korman and Simons, 1978; Tomlinson, 1988), there has been a

tendency in recent years to investigate the national as well as the local barriers to implementation (Hardy, 1985; Korman and Glennerster, 1990; Pettigrew et al, 1990)

The Research Questions

The present research provides a detailed empirical longitudinal analysis of four closure proposals at DHA level within the maternity services policy area. It focuses on the dynamic process of implementation through time using a multiple process perspective. This should help in answering some of the fundamental questions such as: was there evidence of variability in the depth, rate and pace of implementation? what affects the pace and rate of implementation? why is it that centrally-formulated policy does not get implemented ipso facto as prescribed? what affects the 'implementability' (Quick, 1980) of such a proposal? Building on the conceptual framework above, the specific research questions can be summarised as follows:

- What role does central policy play in the genesis of the proposals? How do the districts respond to policies emanating from higher tiers? How does the apparatus and process of implementation get started?
- What are the main impediments and facilitators in the implementation process? What are the varying effects

of culture, leadership, and political skill on the implementation and change? How can the success and failure of implementation be explained?

This chapter has outlined the research framework, reviewed the literature on implementation of closure in the NHS, and enumerated the main questions that will be dealt with in this study. The next chapter will describe the research methodology.

CHAPTER FOUR

The Research Process

Studying implementation poses a number of practical methodological problems for field researchers. These problems arise from the complexity of the concept of implementation (see Chapter one) and from the difficulty of studying organisational processes. In the following section the general research approach is presented. Next, the process leading to the decision to investigate the closure of GPMUs in the Oxford health region is described. The data collection process is introduced, followed by the general approach guiding the presentation of results and the data analysis. Finally, a summary concludes this chapter.

General Research Approach

One of the fundamental methodological issues relates to whether implementation should be studied using quantitative or qualitative methods. Basically, the traditional textbook approach in social science methods suggests that qualitative research should be conducted where quantitative study is not feasible. For instance, Dooley (1984) indicated that,

"Qualitative research may be the preferred method when hypotheses cannot be operationalised in quantitative terms. One instance of this is when theory is

insufficiently developed to provide well-defined hypotheses. Another is when the natural social situation provides the only or best laboratory but cannot be entered with the usual standardised measurement techniques" (p.274)

Implicit in this approach is the assumption that quantitative research is generally preferable to qualitative research which is often portrayed as less scientific and inferior. This reasoning accounts for the fact that social scientists using qualitative methods never seem to tire in telling their readers that their methodology and, therefore, their general approach is also a scientific one (Zetterberg, 1965).

In recent years a number of writers such as Glaser and Strauss (1967), Van Maanen (1979, 1983), Mintzberg (1979), Strauss (1987), Pettigrew (1973, 1990), among others, have sought to establish the qualitative methodology in its own right. Setting apart the training and the philosophy of knowledge of the investigators, it has been argued that the primacy of emphasis between qualitative and quantitative methods depends on the circumstances of the research and on the kind of data needed by the researcher (Glaser and Strauss, 1967).

The present research is essentially qualitative. My association with the precepts of the phenomenological perspective of social science (Deutscher, 1973; Schwartz and Jacobs, 1979) and my

personal interest in understanding daily life and activities of health care organisations from the manager's point of view condition both my choice of the broad research question and my strategy of research. As Taylor and Bogdan (1984) pointed out,

"Since positivists and phenomenologists take on different kinds of problems and seek different kinds of answers, their research demands different methodologies. Adopting a natural science model of research, the positivist searches for causes through methods such as questionnaires, inventories, and demography that produce data amenable to statistical analysis. The phenomenologist seeks understanding through qualitative methods such as participant observation, in depth interviewing, and others that yield descriptive data. In contrast to a natural science approach, the phenomenologist strives for understanding on a personal level the motives and beliefs behind people's actions" (p.2)

The circumstances of the research also played in favour of using qualitative research. There has been little empirical research on implementation particularly in the NHS (see Chapter three) from which to draw a list of the important factors which could be measured. Implementation phenomena are still poorly understood and, therefore, a quantitative approach would have suffered from not knowing exactly what to measure. The research activity cannot be constrained by the boundaries of existing hypotheses. Under such circumstances there is an obvious need to gain a better understanding of the issue and to discover what is

important before valid and reliable quantitative measures can be made. It should be stressed that the broad objective of this research, given the present knowledge of the implementation phenomenon, is to develop concepts, insights, and understanding from patterns in the data rather than to test hypotheses. Qualitative methods have been found particularly appropriate for fulfilling such objectives (Taylor and Bogdan, 1984; Walter, 1988; Yin, 1989).

Finally a further major influence on the research method adopted in this dissertation was the kind of data needed to fulfill the requirements of the processual (Van de Ven, 1986) contextualist research (Pettigrew, 1985, 1987, 1990). As Pettigrew (1990) pointed out,

"The key points to emphasize in analysing change in a contextualist mode, are firstly the importance of embeddedness, studying change in the context of inter-connected levels of analysis. Secondly, the importance of temporal inter-connectedness, locating change in past, present, and future time. Thirdly, the need to explore context and action, how context is a product of action and vice versa; and finally the central assumption about causation in this kind of holistic analysis, causation of change is neither linear nor singular - the search for a simple and singular grand theory of change is unlikely to bear fruit. Explanations of change are bound to be holistic and multifaced" (p. 5)

Such an analysis places emphasis on the richness of the data base. According to Pettigrew (1990), the

comparative case study method satisfies the conditions of contextualist analysis.

"Given all the variants of longitudinal research sketched by Kimberly (1976) Miller and Friesen (1982) and others, why have we adopted the comparative case study method? The simple answer is because the longitudinal comparative case method best suits the research topic we are pursuing, the contextualist mode of analysis we adopt, and the broad research objectives we have in mind" (p.8).

Pragmatism dictates, however, that only a relatively small number of organisations can be investigated. One of the limitations of this study relates to the small sample size: caution is therefore required in generalising the results.

In summary, the richness and complexity of the implementation phenomenon demands a methodology which is capable of capturing in-depth the intangible aspects of process and the rich and intricate logic of implementation. The quantitative methodology has been criticised for its failure to deal with the complex issues of process (Pettigrew, 1973; Van Maanen, 1979), and for over-emphasising rigour at the expense of richness (Mintzberg, 1979; Hardy, 1985).

Focusing the Dissertation: From the "Implementation Gap" to the Closure of GPMUs in the Oxford Region

An important feature of the present research is that it did not start with the specific and clear intention of studying the closure of GPMUs. As Sternberg (1981) pointed out,

"Contrary to dissertation mythology, the choice of a dissertation topic is not an inspirational point in time but a rather extended process." (p.73)

I began looking intensely for a viable dissertation topic with my doctoral studies in October 1985. By Summer 1986, after having produced a review of the British and American literature on strategic planning in health care organisations, a dissertation proposal highlighting the core problematic of my research, the implementation gap, was submitted and accepted. There was then no mention of the specific issue of GPMUs. I had still then to decide upon a clear focus of analysis. Because of the critical requirement that data for the dissertation must be available and accessible, it was felt that such an issue ought to come out of a feasibility study and preliminary field work.

A summary of the proposal was then prepared and submitted to the General Manager/Medical Officer of the Oxford Regional Health Authority via the Regional Planning Administrator. The decision to conduct the

feasibility study in Oxford was based on two main reasons. First, the Oxford RHA was the only Region to have moved from above to below its RAWP target (see Chapter five). At that time, this was interpreted as a general indicator of its capability in managing change and in closing the "implementation gap". Second, it was also motivated by logistics. As indicated above, the present research is essentially qualitative. As Dooley (1984) pointed out,

"While quantitative research may or may not take place in the field, qualitative research necessarily takes place in the natural setting" (p.281).

This means that the setting which is investigated must be accessible to the researcher. Oxford is located within one hour by car from the University of Warwick and fulfils this essential condition.

Gaining access to organisations is one of the critical but often difficult and lengthy steps in the research process (Taylor and Bogdan, 1984) especially for a foreign Ph.D. student. Some of the people interviewed, particularly during the early days of the research, insisted on the complexity of the NHS and expressed scepticism on my ability to understand it. A comment from an interviewee illustrates this point:

"I have been working in the NHS almost all my life and I still don't understand very well how it works. It is a large and complex British institution. It is unique in the

whole world you know. Any way, good luck!
If you ever find out how it works, please let
me know".

Three broad conditions were raised by the Regional officers in order to support the project: (1) privacy would not be invaded, names of individuals would not be used, and sensitive information which is not in the public domain would remain confidential; (2) the design of the research would ensure that the data collection process did not take too much time with individual managers either at the Regional or at the District levels; and (3) there would be no requirement for financial commitment on behalf of the RHA, DHAs, and Units involved. These three conditions were accepted. The first condition is reflected in the data presented in chapters six to nine whereas the second condition affected the data collection process. Because the research entailed the co-operation of most DHAs, the Regional General Manager sought the support of the DGMS and permission to carry out the research in the region was finally obtained in December 1986.

Meanwhile a review of the five strategic plans as well as the planning guidelines and reports produced by the ORHA since its inception in 1974 was made. It soon appeared that the key to the successful implementation of the 1984-1994 regional strategic plan was the transfer of resources from acute and maternity services

towards the priority groups (see Chapter five) and I decided to carry on the search for a specific research issue in that general direction. This was made with three broad criteria in mind. First, the potential issues should cover a change which can be defined. As Stocking (1985) pointed out,

"This may sound obvious but it is not quite as easy as it first appears. With some innovations it may be very difficult to decide whether the innovation is going on or not. Even if those involved say they are now carrying out a new procedure, it is sometimes questionable whether the originators would even recognize it" (p.5).

Second, the issues should provide cases of successful implementation as well as examples of failure. As Korman and Glennerster (1985) indicated:

"If we are to understand policy making (and its implementation) we must study the process by which original intentions are modified or frustrated" (p.5)

Thirdly, the issues should be original in that they should not be studied in the major CCSC research on the management of strategic service change in the NHS. This was motivated by the desire to add to the Centre data base without prejudice to its activities.

Two specific issues emerged from this search: (1) the provision of day care services in surgical disciplines; and (2) the association of GPMUs and consultant obstetrician wards. The second issue was

ultimately preferred for a number of reasons. There was a major ongoing inquiry on the implementation of day care services in surgery conducted by the RHA planning officers and they were concerned that my research might interfere with their work. More importantly, although the region's notable RAWP pace of change, Oxford was lagging behind most of the other regions in implementing the central government's intention to close the peripheral GPMUs (see Chapter five). This represented an intriguing paradox and an obvious example of "implementation gap" at the macro-implementation level.

There was also clear evidence of the implementation gap at the micro-implementation level. The DHAs have been responsible for the closure of the local health care facilities since the 1982 reorganisation (see Chapter five). By 1986, four out of the five DHAs with peripheral GPMUs in Oxford had produced a formal closure proposal for consultation. The outcome of these consultation processes can be divided into two groups: (1) two DHAs had reached a local agreement; and (2) two had been referred for Ministerial decision. In each of these two groups one proposal was successfully implemented whilst the other one failed. Table 4-0 summarises this natural research design for studying implementation and specifies the

sites involved. The table includes the whole population of proposals submitted for consultation by the Oxford DHAs from their inception to the beginning of the research field work. Altogether, they present a full picture of the possible outcomes of such a process.

Table 4-0
Consultation/Closure Matrix
Oxford RHA
From 1982 to 1986

Outcome of the Consultation	Outcome of the Proposal	
	Success	Failure
Local Agreement	Isebrook GPMU (Kettering DHA)	Abingdon GPMU (Oxfordshire DHA)
Ministerial Decision	Bletchley GPMU Westbury Maternity Home (Milton Keynes DHA)	Amersham GPMU (Wycombe DHA)

A further reason for the choice of this issue relates to the quality of the documentary material available at both RHA and DHA levels on the proposals as well as on the facilities involved. A final reason relates to the quality of access to the settings. The closure of GPMUs represents a symptomatic yet non-threatening issue for the various organisations and

most of their members as few resources were at stake. That increased the probabilities of negotiating access. As Child and Smith (1987) pointed out,

"The high quality access provided by an organisation is an indispensable, but rarely granted, requirement for qualitative, contextual, research into process of organisational change" (p. 203).

To summarise, in this research, the three traditional field research processes of: (1) focusing from a broad research problematic to a specific research issue; (2) gaining entree to the organisations; and (3) selecting interesting sites for research, were not linear-sequential as generally pictured in most prescriptive textbooks on social research methods. These processes ran concurrently and were muddled. They were incrementally driven by a combined search for scientific rigour, richness of the data-base, and pragmatism. Such a way of conducting research is, however, not uncommon in qualitative research. As Taylor and Bogdan (1984) indicated,

"Qualitative researchers are flexible in how they go about conducting their studies. The researcher is a craftperson. The qualitative social scientist is encouraged to be his or her own methodologist (Mills, 1959). There are guidelines to be followed, but never rules. The methods serve the researcher; never is the researcher a slave to procedure and technique" (p.8).

However, the Oxford health region represents an extreme case as opposed to a typical example of how the regions dealt with the issue; it has been a "late adopter" (see Chapter five) of the policy. One should, therefore, be cautious in extrapolating the findings to other health regions.

The Data Collection Process

The data collection process comprised three main activities: (1) documentary search; (2) in-depth interviews; (3) observational and ethnographic material. This section describes the purpose of each activity, elaborates on the methods used, and stresses some of the problems and limitations.

The data collection was carried out in two phases - an approach particularly recommended by Glaser and Strauss (1967). In the first phase an analysis of a wide range of documentary and archive material was made. Broadly, this phase began in March 1987 in Wycombe, June in Milton Keynes, September in Kettering, and in October in Oxfordshire. In the second phase, the key participants were interviewed. The last interview was held in Oxfordshire in April 1989.

The aims of the first phase were: (1) to obtain a detailed history of how the case developed over time; (2) to identify the key participants in the implementation process; and (3) to reduce the time

spent with individual managers as requested by the Regional General Manager. Interviewees were not requested to recall the precise chronology of events but encouraged to describe their experiences and to clarify their motivation and action. I found it important to obtain as much documentary evidence as possible prior to the interview stage particularly since, as a French Canadian, I was not totally fluent in English. The factual information obtained was of great assistance in structuring interviews as well as in probing for details and sometimes to jar the interviewees' memory.

At the regional level, the researcher was given unrestricted access to the headquarters archive department and to the library. Specifically, the following sources were used to develop the implementation chronologies: minutes and relevant papers of meetings from the Regional Health Authority, the Regional Team of Officers, the Regional Planning Group and other bodies and project planning teams, files relating to closure of hospitals and services, and files concerning the GPMUs and the maternity hospitals.

At the district level, strategic and operational plans, minutes and papers of District Planning Teams as well as District Health Authority minutes, Planning

Teams and Consultative Committee minutes were also perused. In all cases the researcher was given access to complete DGM's files which included correspondence, memos, and notes on meetings.

At unit level, the files were consulted only in Amersham and did not yield genuinely new insights. The CHCs' files which included correspondence, responses to consultative documents, newspaper articles and press releases were also consulted.

Overall access to the documents was best in Wycombe, almost as good in Kettering and Oxfordshire, and rather less complete in Milton Keynes. Greater difficulty was experienced in the latter case partly because all the files had not been transferred from the previous districts to the new DHA and partly because of selective survival of the files since the proposal was put forward in 1982, particularly at the CHC.

The second phase was based on in-depth interviewing.

"By in-depth qualitative interviewing we mean repeated face-to-face encounters between the researcher and informants directed toward understanding informants' perspectives on their lives, experiences, or situation as expressed in their own words" (Taylor and Bogdan, 1984, p. 77).

The main aim of Phase 2 was to identify the motivations and actions of the people involved in the process and to record the factors which, according to them have

influenced implementation. The interviews were semi-structured and, on average, lasted for one and a half hours. The pro-forma of questions and issues which was used as a checklist for the design of the individual interviews is given in Appendix A. These questions were based on the analytical framework and on the original research questions presented in Chapter three. They were supplemented by the outcome of the Phase 1 of the data collection process.

The majority of interviews were conducted on a one to one basis and all were tape-recorded and transcribed verbatim. No respondents objected to being recorded but some requested that the machine be switched off at certain times in order to comment on sensitive issues. These issues can be classified into three broad categories: (1) features of the personality of the key people involved; (2) conflicting relationships among them; and (3) hidden motivation for action.

As part of the first phase of the data collection, potential informants were identified. At the end of each interview, the informant was invited to introduce other key individuals who played an active part in the process. A particular effort was made to interview the "product champions" (Stocking, 1985) in each case, the leaders of the public campaign, and representatives of the various professionals concerned.

Representatives of relevant interest groups directly involved were interviewed. These groups included: DHSS and Regional officers, District officers, Unit officers, CHCs, GPs, Obstetricians, Midwives, employees and public action committees. For instance, at Wycombe, I interviewed the current and the previous chairmen, the DGM, the various members of the DMT including the Nursing Officer, the Medical Officers, the Treasurer, the District Administrator and the Consultant and the GP representatives, the UGMs, the Director of Planning and the Planning Officer, the Chief Nursing Advisor, the Patient Services Managers, the Administrator of the Family Practitioner Committee, the Secretary to the CHC, the Joint Trade Union Committee Secretary, two midwives, two members of the public action group, the representative of the local branch of the NCT. Twenty different individuals were interviewed, several of them more than once since two different proposals were investigated.

The lists of people interviewed in Kettering and in Milton Keynes roughly compare with the list above. Fewer interviews were, however, held in Oxfordshire. In this case I interviewed: the DGM, the Medical Officer, the Assistant DGM/Planning and Performance, the UGMs, the AHA Planning Officer, the Secretary to the CHC and his assistant, the GP representative, the

District Planning Nurse, the Chairman of the Maternity Support Group, and a midwife. Many of them were interviewed on two different occasions since, as in the case of Wycombe, two different proposals were investigated. The perspectives of the various participants roughly coincide and it was felt that interviews with additional people would not yield new insights.

Finally, interviews were also conducted with DHSS and Regional officers as well as with various individuals outside the NHS with knowledge of GPMU's operation. These included representatives of the Royal Colleges of Obstetricians and Gynaecologists, General Practitioners, Midwives, the National Birthday Trust Fund, the National Childbirth Trust, the Association of GP Hospitals, and the National Perinatal Epidemiology Unit in Oxford. In total, more than 100 interviews were held between January 1987 and April 1989.

Information obtained from interviews is subject to a variety of well-known problems such as bias, poor recall, and inaccurate articulation (Yin, 1989; Walker, 1988). Some interviewees, particularly in Milton Keynes, had difficulty recalling the chronology of events without some prompting. This was not the case in the other districts because the development of the proposals was partially followed in real time with

interviews taking place during or relatively shortly after the events had occurred. Certain actions were undertaken to increase the reliability and validity of this study: (1) the quality of the overall data base has been improved by multiple interviewing; (2) interview material has been checked against documents and records; (3) key informants have reviewed draft case-study reports; (4) multiple case-studies were investigated using a common pro-forma of questions and issues providing regularity and patterning.

Finally, unobstructive measures such as government statistics, district performance reports, and financial reports were all used to supplement interview material. Observational and ethnographic activities such as site visits and attendance at formal meetings also took place. From March to September 1987, I attended the meetings of the working party on the re-opening of the Amersham GPMU in order to get first hand experience of the management of the issue and to observe the group dynamics. Informal chance meetings over lunch and telephone conversations also proved valuable sources of data.

In summary, the data collection involved three main activities: documentary search, interviewing with key informants, and observational as well as ethnographic material. In terms of the sequencing of

the data collection, the chronologies were established first using archival data and a few interviews, followed by the interviewing, secondary data collection and informal questioning. The triangulation of these sources of evidence and the relatively large numbers of interviews provide some assurance that the data collected is reasonably valid and complete; albeit, the data collection in Milton Keynes was a little more difficult than in the other three districts.

Data Presentation and Analysis

The data gathering process generated a mass of information. By far, the most difficult part of this research was the presentation and the analysis of the empirical material. A limitation of the present research is that the analysis relies on the perception of one researcher. The challenge was to find ways of identifying the patterns through an immersion in the data without drowning in the details.

As for the other activities of the qualitative research, there is no absolute rule on either presentation or in the analysis of qualitative data. As Jones (1988) pointed out,

"The analysis of qualitative data is a highly personal activity. It involves processes of interpretation and creativity that are difficult and perhaps somewhat threatening to make explicit. As with depth interviewing there are no definitive rules to be followed by rote and by which, for example, two

researchers can ensure that they reach identical conclusions about the set of data" (p.56) .

According to Yin (1989), there are, however, two broad categories of analytic strategies in case study research: (1) relying on theoretical propositions; and (2) developing a case description. Basically, the first approach is a close analogue to the positivist model of research and aims to test a priori propositions. It should be stressed once more that the objective of the current research is to evoke possible hypotheses rather than to test theoretical propositions. The purpose of this research must clearly be classified as exploratory. In contrast, in the second approach, the general analytical strategy is to develop a descriptive framework for organising the data. This has been the analytical strategy favoured by, for instance, Korman and Glennerster (1985, 1990), Hardy (1985), Pettigrew et al (1990), and the one adopted in this research.

Three broad sections form the basic descriptive framework: (1) the genesis of the proposal; (2) its development; and (3) its conclusion. This structure was adopted as a substitute to the initial chronological presentation of the data because it grants the opportunity to highlight the key factors and features of the case and to establish early analytical

themes inductively derived from the case whilst keeping a broad temporal presentation needed to lay out the narrative.

The analytical challenge of contextualist research is to link up the content, contexts, and processes of change over time to explain the differential achievement of change objectives (Pettigrew, 1990). The approach used here relies on a combination of elements of systematic analysis such as chronology, tables, figures, and the researcher's own hunches developed through immersion in the data and repeated readings of documents and interview transcripts.

Summary

This chapter has outlined the problem of researching a complex phenomenon such as implementation. It has been argued that a qualitative approach was most appropriate because of the richness and complexity of implementation, the circumstances of the research, the kind of data needed in analysing change in a contextualist mode, the philosophy of knowledge and the skills of the researcher.

The study focuses on the implementation of peripheral GPMU closure proposals in the Oxford health region. The issue represents a clear example of an implementation gap at both the macro and micro-implementation levels. The data collection process

comprised three main activities: documentary search; in-depth interviews and observational as well as ethnographic material. A very rich data base was developed. The use of multiple data sources provides some assurance that a relatively complete and accurate picture of implementation was obtained. The study does suffer, however, from the limitations traditionally associated with the qualitative research: (1) small sample size; and (2) data analysis relying on the perception of one researcher. A number of measures have been taken in an attempt to alleviate these problems but caution is still required in generalising the findings.

The general strategy of data presentation and analysis was to develop a descriptive framework for organising the case-studies (Yin, 1989). The analytical approach relied on a combination of systematic analysis and intuition developed through immersion in the data.

CHAPTER FIVE

The Maternity Services Policy and Its Changing Context

The next four chapters deal with the permanent closure of GP maternity services in Oxford DHAs. The structure of the NHS and its bureaucratic process for dealing with closure are relatively complex. This chapter presents the structure of the NHS as well as the closure procedures and guidelines. Of all the major British institutions, the NHS has, since its inception had one of the highest levels of public opinion support. This chapter begins by highlighting the unique place held by the NHS in recent British political history.

In line with the theoretical imperative of the research, it is necessary to investigate the implementation of the policy in its historical context. The next part of the chapter outlines the changes which took place in maternity policy and in the role of GPs in obstetric care since the beginning of the century. It is not the intention of this chapter to analyse and explain the root causes of these changes. Rather, the objective is to describe certain trends and characteristics which are important in understanding the implementation of the GPMU closure proposals described in the next chapters.

Finally, this chapter examines the pattern of local response to the current central government in-patient maternity facilities policy. The Oxford RHA Strategic Plan and its strategy for in-patient maternity services are outlined; this chapter ends with a concluding summary.

The Political Context

Next to the monarchy, the NHS appears to be Britain's most popular institution. Historically all post-war politicians in the UK have been duty-bound not to be seen as attacking the NHS.

The NHS was established in 1948 and its creation has been described by one of its architects, Mr Michael Foot, who in November 1980 became leader of the British Labour Party, as the Labour Government's most intrinsically Socialist proposition. As Klein (1985) pointed out:

"To this day the NHS symbolises the Labour Party's vision of a Socialist society. It is a service which offers free access to health care to the entire population as a right of citizenship, regardless of the ability to pay. It is a service which recognizes only one criterion for allocating resources to individual patients, that of need as defined by the professional providers of health care. It is a service, furthermore, which is overwhelmingly financed out of general taxation, and which is thus a powerful instrument for redistributing money from the working population to the sick and the old. Not surprisingly, therefore, the NHS symbolizes in British eyes social equity and collectivist compassion. " (p.42)

Until 1979, successive governments, both Conservative and Labour, had almost unconditionally committed themselves to developing the NHS. As Wilding (1989) indicated:

"The consensus about the Welfare State which existed from 1945-1975 can easily be over-emphasised. There were differences between the main political parties about what should be done and how quickly, but there was near universal acceptance of the major role of the state in welfare which had emerged in the years between 1945 and 1950. There was little question about that principal." (p. 185)

The 1980s have been an important and somehow unusual decade in British political life. A new word, "Thatcherism", entered the political lexicon (Jessop et al, 1988; Hall and Jacques, 1990; Gramble, 1990). First elected in 1979, the Conservatives subsequently won both the 1983 and 1987 general elections. Thus, Mrs Thatcher became the only Prime Minister ever to be re-elected after two consecutive full terms since Lord Liverpool in the 1820s.

The Thatcher governments have been implementing a new "radical" Conservatism which has rejected most of the post-war legacy of the Conservative party itself. The approach became known as "political monetarism". Besides her exercise of Prime Ministerial power and the encouragement of "Victorian values", one of Mrs Thatcher's key features (Kavanagh, 1990 a,b) has been

her fundamental opposition to Labour party privilege based on the public sector:

"Much of Thatcher's legacy from previous leaderships was philosophical in terms of the social obligations of Conservative governments ... When Mrs Thatcher came to office in 1979 the emphasis had switched away from accepting welfarism as a policy objective and towards individual self-reliance and thrift. The private sector was stressed and the public sector subject to scrutiny as to the desirability of its component parts ... Similarly, although the Thatcher approach to the Health Service and the social welfare system was to maintain state provision, this was - in theory at least - regarded as less significant than before as a hallmark of Conservative rule" (Holmes, 1985, p. 12).

The decade witnessed a clear move towards transferring the ownership of major British public service institutions - telephone, gas, electricity, and water - into private hands. Amidst these changes the NHS could clearly not remain unaffected.

In the 1979 Conservative election campaign, four main themes featured alongside the party's motto "reinvigorating the private, wealth-creating sector of the economy": (1) the reduction of public spending; (2) reducing trade union power; (3) tax cuts; and (4) inflation. During the first two years of the 1980s, government popularity plummeted. The Labour party dominated the opinion polls and there were several by-election defeats for the Conservative Government. As a result, the Prime Minister was vulnerable. A proposal

for dismantling the NHS had been tentatively floated in the party's 1979 election manifesto. However, the repeated attacks of the Labour party, pressure from the Cabinet left-wingers, and the outcry of the welfare state lobby in the Conservative party in particular, led to the idea being effectively abandoned and forced the Prime Minister to repudiate the proposal at the 1982 annual party conference.

There is little doubt that Mrs Thatcher's handling of the Falklands campaign - which began with the Argentine invasion in April 1982 - greatly assisted her re-election chances, but the Conservative's new key campaigning theme "the NHS is safe with us" clearly contributed significantly to winning re-election in 1983. The new enthusiasm of the Conservatives for the NHS was symptomatic. As Klein (1985) pointed out:

"the best evidence of the continuing strength of the consensus supporting Britain's existing health care system comes precisely from the Thatcher government's born-again enthusiasm for the NHS: an enthusiasm all the more significant because it represents the tribute paid by ideological bias to political necessity" (p.56).

Once again the NHS became a central issue during the 1987 general election. It was brought back onto the electoral agenda by the new Labour party leader, Mr Neil Kinnock. The government spending record on the NHS and the expansion of the private health care sector

were the key watchwords of Labour's campaign. The aim was to wrongfoot the Conservative government on its renewed commitment to the NHS. The complexity of the argument meant, however, that this proved very difficult to achieve.

"From the government perspective, the growth of spending of health care is presented as evidence of its commitment to the NHS. The drop in the growth rate is less important and significant, it is argued, than the fact that there has been any increase at all in spending in the NHS in the period when the overall performance of the British economy has been truly dreadful. Consequently, any increase in expenditure could not be financed out of the dividends of growth but meant transfer of resources from private consumption to public spending. From the perspective of the government's critics, in contrast, the spending record is evidence of the Conservative's niggardliness which, it is argued, is undermining the NHS. The price of financial stringency, the critics maintain, is cutting the NHS and reducing its ability to respond to need" (Klein, 1985, p. 43).

The Labour party's leadership difficulties, its "failure to translate its ideas into clear policy commitments" (Small, 1989, p.117) and the unpopularity of the Labour's defence policy in particular contributed to the Conservative party's own strengths in the 1987 Conservative re-election.

In summary, the British NHS is a highly sensitive political issue. Throughout the 1980s, the NHS has been at the core of the political confrontation between Thatcher's Conservative party, which has gained the

overall parliamentary majority on three consecutive occasions, and "Her Majesty's Opposition", the Labour party. Such a critical issue at national level is bound to reflect on local politics when health care issues, such as the closure of health facilities, are raised by the local Health Authorities.

The Structural Context

The NHS was first reorganised in 1974 by the Heath Conservative government in a measure to unify its original tripartite structure. This was achieved by bringing together the hospital, community and preventive services under 14 Regional Health Authorities (RHAs) - responsible for populations varying from nearly 2 to over 5 million. Below these were 90 Area Health Authorities (AHAs) which were further sub-divided into a number of geographical districts and units of management.

Gradually it became apparent that the structure was over-elaborated, and the NHS was further reorganised in 1982 by the first Thatcher government. The AHAs were abolished and replaced by 192 District Health Authorities (DHAs) directly responsible for the planning, development, and management of a total of about 900 units. In each RHA, there were between 8 and 22 DHAs, each of which had 2 to 10 units. The Chairmen of these Authorities are appointed by the Secretary of

State and receive a small, part-time salary. This structure largely remained in force throughout the period of the research.

In parallel with this process of reorganisation, the government introduced a strategic planning system as well as a procedure of accountability reviews. As Korman and Glennerster (1990) pointed out:

"Under this system, regions and districts had to respond to questions from the central department about their progress towards key policy goals" (p.27).

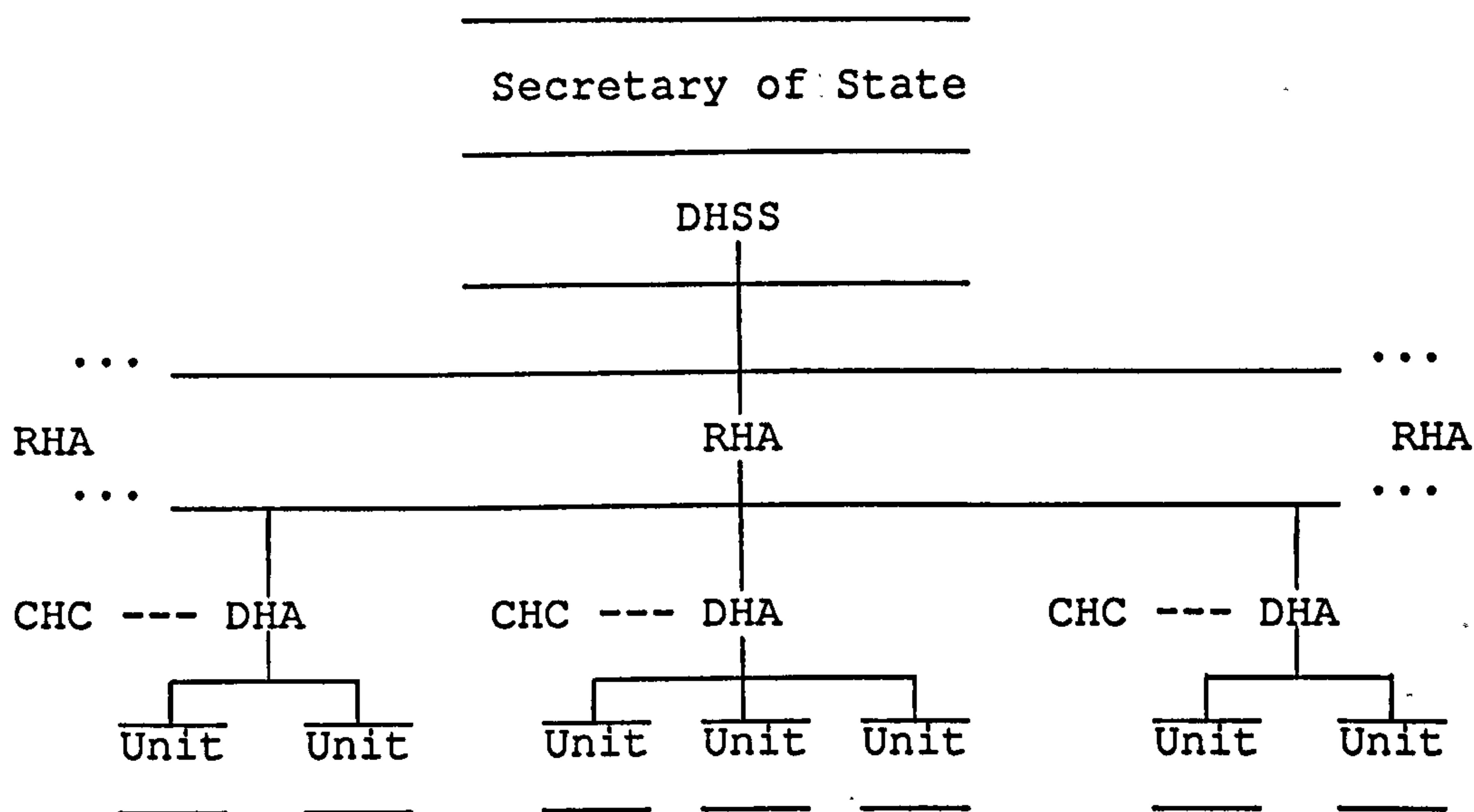
In 1985, however, there were further management changes resulting from the implementation of the recommendations of the NHS Management Inquiry Report (the Griffiths report), commissioned by the second Thatcher Conservative government's Secretary of State, Mr Norman Fowler. Prior to this inquiry, each RHA appointed a Regional Team of Officers (RTO). In the same way each DHA appointed a District Management Team (DMT) comprising of functional managers as well as elected medical representatives. The DMT reported directly to the DHA, and the District Administrator worked directly to the Chairman. The DMT had no permanently designated head but members took it in turn to preside over meetings. These key decision-making groups were operating by consensus.

Although the Management Inquiry Team did not reject systematically the consensus management, one of its major recommendations was to identify clearly a General Manager at regional, district, and unit levels. The recommendation was approved by the Ministers and implemented in 1985. The General Managers took personal responsibility for planning, implementing plans, and controlling the performance of their organisations. The resulting management arrangements differed among the various regions and districts, from the retention of the RTO and DMT in their previous form to major changes and reorganisation of functions at all organisational levels. A schematic structure of the NHS is presented in Figure 5-0.

Figure 5-0

**Schematic Structure of the NHS
(excluding Family Practitioner Committees
and relationships with other bodies)**

England, 1985



Source: Adapted from Mullen, P. (1985).

For each DHA, there is also one Community Health Council (CHC). The CHCs were not included in the original design for the 1974 reorganisation, but they were championed by the Labour party and appeared during the parliamentary debate. The CHCs were established to be the voice of the consumer but their responsibilities extend far beyond a concern simply for the interests of patients. They are responsible for promoting and protecting the interests of the local population and

are commonly referred to as the "Watch Dogs" of the health services (Farrell and Levitt, 1980).

Normally, the CHCs have 18-24 members. One half of the members are appointed by local authorities, one third by voluntary organisations, and the remaining one sixth by the RHA. The RHAs are responsible for funding the CHCs in their territories but the CHCs are separate and autonomous consumer-representative bodies.

Further reforms in the organisation of the NHS have been proposed in the White Paper Working for Patients, published on 31st January 1989 by the third Conservative government. These reforms were not implemented during the period of the present research. For more details on the key changes advocated by the White Paper see Willetts (1989).

With the structural context now broadly set, the next section considers the DHSS guidance on consultation.

The Bureaucratic Context

Consultation is a key aspect of the NHS system for implementing a permanent closure. The duty to consult the CHCs is laid down by the NHS Regulations, SI 1973 No 2217. General guidance on the circumstances and processes of consultation is available in a DHSS circular, HCS(IS)207, issued in October 1975.

There are a number of difficulties with these documents. One is that they adopt different approaches to consultation, and use different terminology. A further difficulty is that they allow for considerable variation in the timing, scope, and content of the consultation. As Liddell (1981) pointed out:

"The rules and procedures of consultation, as currently framed, present a minefield of complexity and delay, even to the initiated. Established when the scale and pace of change were more modest (or the public less aware), they have been interpreted and developed by custom and practice, and by precedent of ministerial and legal decision. Perhaps most bewildering is the combination of variables introduced but hardly explained by the official guidance, changes which may apply to health buildings or to services, which may be permanent or temporary, partial or total, urgent, substantial or merely part of routine management" (p.32).

Because of these difficulties the DHAs rely generally on their Administrators and, since 1985, on their General Managers to advise on the way to approach each situation. The complexity of the process also has its effect on the CHC members who often feel powerless in fighting the closure proposals (see Health Service Journal, 16 November 1989, p. 1384). As Korman & Simons (1978) indicated:

"When an Authority consults other bodies, it has in effect made up its mind, at least tentatively, on an issue. Because closure procedure is complex, based on a detailed review of provision and needs, there is already a commitment to closure at the time an Authority recommends closure procedures be

initiated. The Authority is still open to influence to the extent that it can be shown that the decision is unacceptable, based on inadequate information or misunderstanding. CHC members, however, see this as a decision already made, and the potential for influencing the decision as minimal" (p.178)

The general rule is that consultation should be as full as circumstances permit. The usual procedure is for the DMT to hold informal pre-consultation with the CHC and the other advisory committees. A consultative document is produced specifying the reasons for the closure, the alternative use of the site and alternative employment of staff, the relationship between the closure and other developments, and the implications for the patients. This is then circulated to a wide range of advisory bodies, staff, and powerful external interest groups. Most of these groups are expected to comment on the closure proposal, which the DHA has to take into account when making its decision.

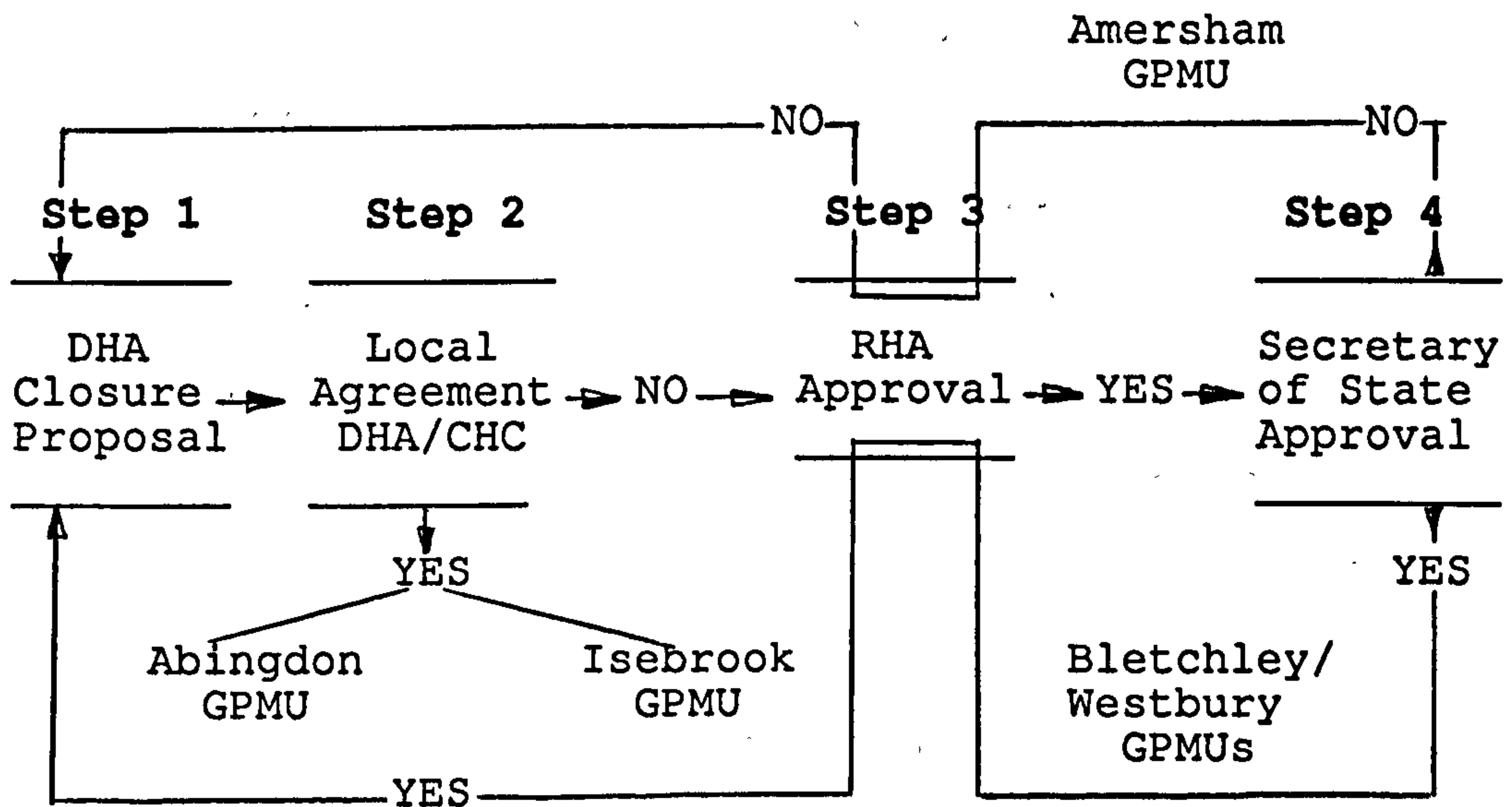
The local CHC has a particularly critical role to play in the process. It has a statutory right to be formally consulted on any substantial variation in the local provision of health care services. The NHS Strategic Planning System implemented in 1982 also makes provision for the local CHC to be consulted on the District strategic plan and forward programmes.

If, on the one hand, the CHC agrees to the closure, then the DHA can go ahead. If, on the other

hand, the CHC objects to the closure it must put forward a detailed and constructive counter-proposal which must be taken into account by the DHA. If the DHA still wishes to go ahead with the initial closure proposal, it must refer the decision to the RHA which, if it supports the DHA, must forward the proposal to the Secretary of State who may or may not confirm the decision to close the service. A summary of the administrative process of closure and the steps followed by each of the case-studies is presented in Figure 5-1.

Figure 5-1

Algorithm of the Sequence of Decisions
in the Technical Process of Closure



With the exception of the first proposal to close the Amersham GPMU, a consultation paper was issued for all cases (Step 1). Two out of the four cases, Abingdon GPMU and Isebrook GPMU, ended with a local agreement between the DHAs and the CHCs on the closure proposals (Step 2). The remaining two proposals, Amersham GPMU and Bletchley GPMU, were referred to the RHA (Step 3) and forwarded to the Secretary of State for arbitration (Step 4). The proposal to close the Amersham GPMU was rejected whereas the proposal to close the Bletchley

GPMU and the Westbury Maternity Home was approved by the Secretary of State.

Full local consultation rarely takes less than six months, and more usually nine or ten months. The timetable may extend to years if a difficult Ministerial decision is involved. This delay is the single most important factor identified by the respondents for negotiating and compromising in order to reach a local agreement on the closure proposal. The savings from closures are calculated at a particular point in time and the longer decisions take to be made, the greater the likelihood that the savings will diminish.

The data on the numbers and outcomes of cases referred for Ministerial decision in the last two decades are not available. In recent years the trend has been, however, for the Secretary of State to be increasingly involved in settling the proposals (Table 5-0).

Table 5-0

Percentage of Closure Proposals Referred
for Ministerial Decision

England

1986 - 1989

Years	Ministerial Decisions		Numbers of Closures	
		%		
1986	9	11.8	76	
1987	13	19.4	67	
1988	5	3.0	132	
1989	23	22.7	101	

Source: Data provided by the DHSS.

This section has briefly described the formal procedure for the closure and change of use of health facilities. For more details on the administrative processes involved see, for example, Dennis et al. (1980), Liddell (1981), and Finch (1985). The next section presents the formation of maternity policy in England, the changing place of the general practitioners in obstetric care, and the context in which it occurred. This analytical chronology of the policy formation has greatly benefited from the work of

Rona Campbell, Department of Social Administration and Policy, University of Ulster, Alison Macfarlane and Miranda Mugford of the National Perinatal Epidemiology Unit (NPEU) in Oxford.

The Historical, Social and Economical Contexts

The main objective of the maternity service policy has always been to minimise mortality in mothers and babies. The following five headings summarise the development of the policy since the beginning of the century:

1. Universal Home Confinement;
2. The Provision of Small GPMUs and Maternity Centres;
3. Confinement at Home, in Consultant Ward, and in GPMUs according to Medical and Socio-economic Risk Factors;
4. Universal Hospitalisation;
5. Rationalisation of all Existing Maternity Facilities.

Universal Home Confinement

During the nineteenth century most women in England and Wales had their deliveries at home. A small number of births were also taking place in charitable lying-in hospitals, founded in the preceding century, as well as in military hospitals and in union workhouse infirmaries, managed by a number of joined local parishes (Abel-Smith, 1964; Crowther, 1981;

Salmon, 1988). A significant proportion of women having deliveries in these institutions were dying following normal labour from various septic conditions known as puerperal fever. The hospital was considered, by those with responsibility for the services, as a potentially dangerous place for childbirth.

Towards the end of the century, the maternal death rates in hospitals were much lower than they were before because of the adoption of aseptic and antiseptic procedures. Nevertheless they were still significantly higher in hospital than in women's own homes.

At the turn of this century, the rising public concern about infant mortality put political pressure on the Local Government Board, the forerunner of the Ministry of Health, to set up schemes for maternity and child welfare. Local authorities were empowered to provide staff for home visiting, help for expectant mothers, clinics, and in-patient beds. A number of maternity centres in buildings separate from hospitals were provided by local authorities, nursing associations, and other voluntary agencies.

The Policy of Small GP Units and Maternity Homes

During the first World War the over-crowding of towns and particularly the poor housing conditions emphasised the need for more maternity homes. At the

end of the war, the Ministry of Health was set up. It had a Maternity and Child Welfare Department, staffed entirely by women, whose task was to co-ordinate and monitor the implementation of maternity policy. The Ministry encouraged the development of maternity homes throughout the country. A distinction was clearly made between maternity homes of up to 20 beds providing for normal cases, miscarriages or cases of minor difficulty, and larger maternity hospitals fully equipped for the treatment of all complications and disorders of pregnancy and labour.

The number of beds increased considerably both in hospitals and in small maternity homes such as in Westbury (see Chapter eight). Under the Local Government Act of 1929, local authorities took over the charitable hospitals and were given block grants by central government to secure the implementation of the services. Many local governments, such as in Amersham (see Chapter six) and in Wellingborough (see Chapter nine), expanded their workhouse infirmaries. The local cottage hospitals (see Chapter seven) also provided a number of maternity beds.

The institutional delivery was already becoming popular with expectant mothers. The percentage of births in institutions rose to 15% in 1927 and 35% in 1937 as a result of both the increase in the

institutional facilities available and a dramatic fall in the numbers of births. The maternal mortality rate in institutions did not, however, fall further. Quite the opposite, it rose slightly during that period to nearly five maternal deaths per thousand births.

Both the British Medical Association (BMA) and the British College of Obstetricians and Gynaecologists (RCOG), founded in 1929, supported the Government's policy. It was, however, criticised by some obstetricians who were calling for fewer well-equipped hospitals, with full facilities for teaching as well as treatment.

The 1930s saw competition between obstetricians and GPs about who should be responsible for maternity care. As Stacey (1988) pointed out:

"GPs were anxious to practice midwifery because this was one of the routes whereby they could influence the woman of the house and thus gain access to the health care of the whole family and increase their clientele." (p. 87)

The move towards institutional delivery was accompanied by changes in obstetric practices. The intervention during labour and the number of operative deliveries such as anaesthesia, forceps, caesarean section and other obstetric operations became increasingly common. Some GPs were, however, inadequately trained to perform these interventions. A proportion of the maternal and

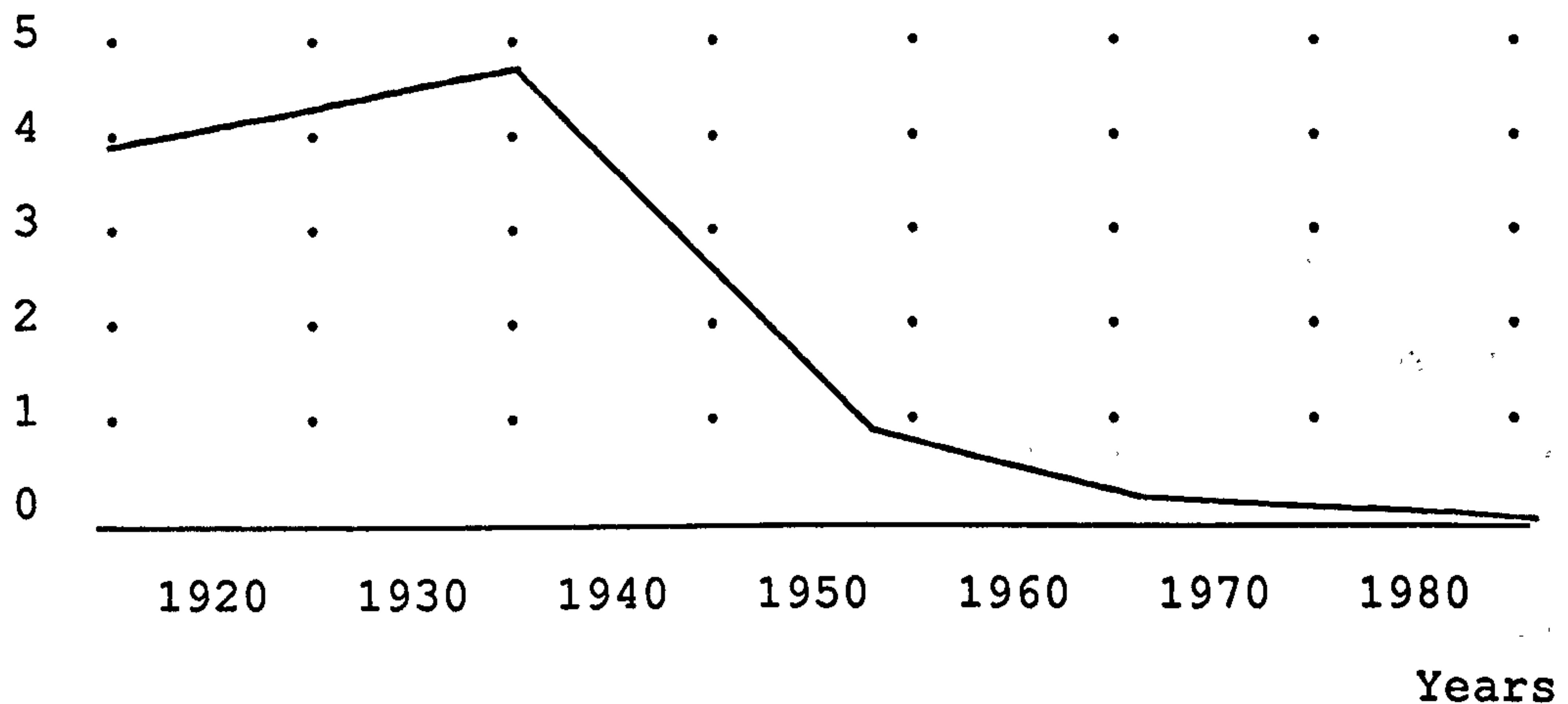
perinatal mortality was attributed to the lack of skill of the GPs and to inadequate care, particularly in units located in small cottage hospitals.

A few years before the second World War, an effective drug for the treatment of puerperal sepsis, the Prontosil developed by a German company, was introduced in England. The maternal mortality rate as a whole and the mortalities attributable to puerperal fever in particular fell sharply (Figure 5-2). The hospital was no longer considered by those with responsibility for the services as a dangerous place for childbirth.

Figure 5-2

Maternal Deaths per 1000 Births
England and Wales
1920 - 1980

Numbers
per 1000
Births



Source: OPCS Mortality Statistics

The provision of more in-patient maternity beds was certainly impeded, however, by the second World War. Nevertheless more than half of the deliveries were already taking place in hospital in the immediate post-war years of the "baby boom". Meanwhile the maternal mortality rate fell further to just over two per thousand births.

The Policy of Confinement According to Medical and Socio-Economic Risk Factors

The proportion of mothers seeking admission to hospitals for their confinements increased further following the inception of the NHS in 1948. As Doyal (1987) stated:

"The creation of the NHS was extremely important for British women, giving them for the first time both primary and hospital care free at source. It was particularly valuable in ensuring that all women were able to obtain ante-natal care and help during child-birth." (p. 215)

In its reply on the White Paper setting out the principle underlying the NHS, the RCOG recommended that NHS maternity accommodation should be provided to allow for 70% of all births to take place in hospital.

This suggestion was not immediately adopted by the Ministers. The demand for acute hospital beds was outstripping the supply. The provision of hospital accommodation, particularly for normal maternity cases, was not seen as legitimate by the authorities. The hospital care was reserved for the more difficult cases. The tendency was still to see pregnancy as a natural physiological event with departures from the normal occurring solely in some cases.

The changes which took place after the war in the pattern of care available to women and babies, the improvements in general medical care, and the general increase in living standards made a substantial

contribution to improving all mortality rates and the maternal mortality rate in particular. In the first half of the 1950s, the mortality of mothers fell to less than one per thousand births and it became possible for every maternal death to be the subject of a detailed medical inquiry. The first report on these inquiries pointed to the booking of high risk women for delivery at home or in small GPMUs. In this period came the belief that the GPMUs were unsafe.

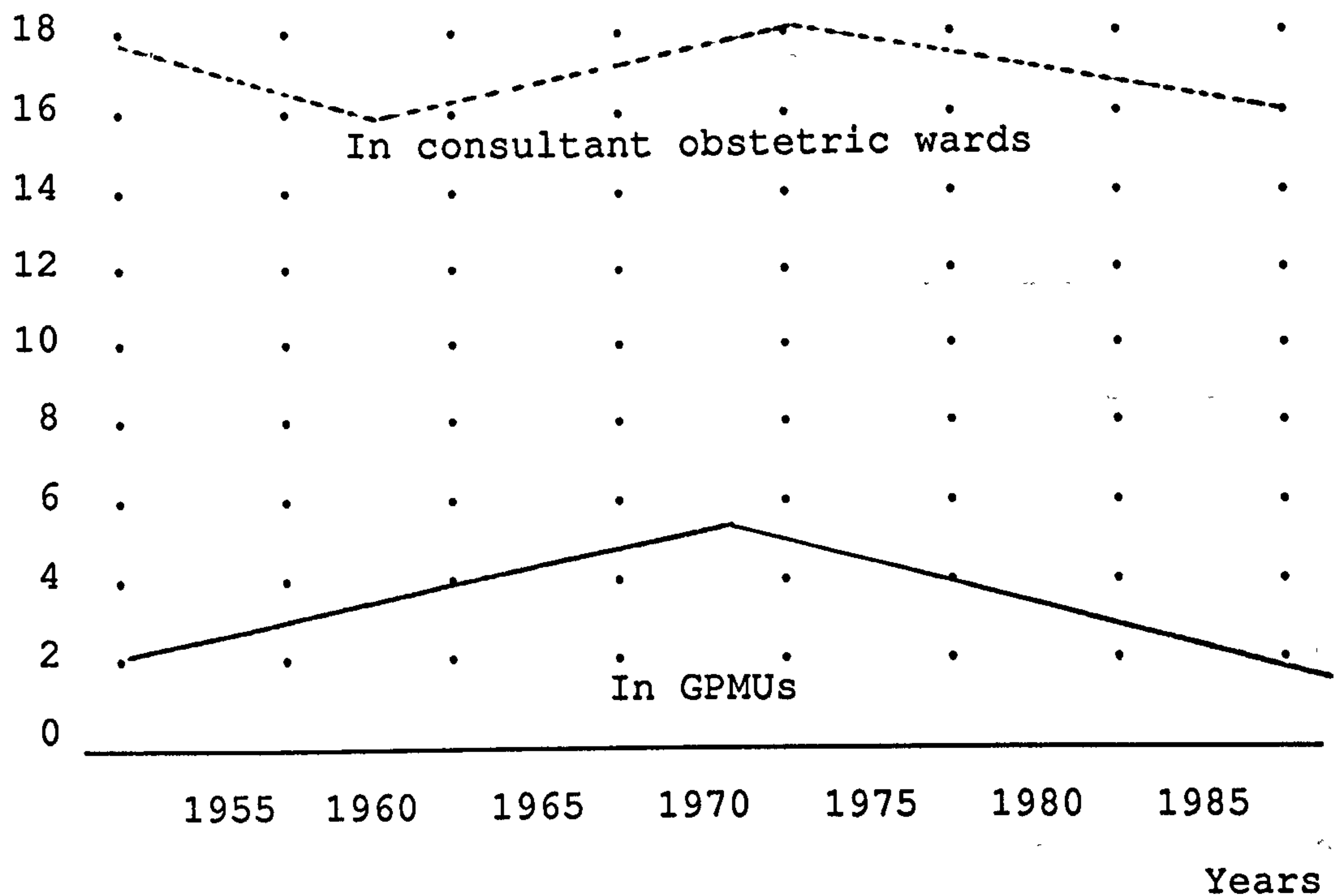
The selection of women to deliver in hospital was a recurring theme in the 1950s and in the first half of the 1960s. Up to 1962, the percentage of births taking place in hospital remained relatively static at about 60 to 65 per cent. This was made possible in spite of a sharp increase in the total number of births by the opening of new facilities such as in Bletchley (see Chapter eight). The number of maternity beds both in consultant obstetric units and in GPMUs increased steadily to peak only in the first half of the 1970s (Figure 5-3).

Figure 5-3

Numbers of Beds in Obstetric Wards and in GPMUs
England and Wales

1955 - 1985

Numbers
(x000)



Source: Adapted from Campell & Macfarlane (1987).

At the same time there was a substantial increase in the productivity of all these beds and a sharp decrease in the average length of stay in particular (Table 5-1)

Table 5-1

Average Length of Combined Antenatal
and Postnatal Stay

England

1955 - 1985

	1955	1965	1975	1985
GPMUs	11.1 days	7.6	5.2	3.6
Consultant beds	12.1 days	8.6	7.2	4.7

Source: Data from Ministry of Health, DHSS Office Publications.

In the 1950s, the maternity homes and the maternity units located in small cottage hospitals became known as GP units, whilst midwives maintained responsibility for nearly all the maternity care including supervising the deliveries. By the late 1950s, they were already referred to as "isolated" GPMUs in some official reports. The new name

emphasised the lack of proximity to specialist obstetric services. It contrasted these GPMUs with the new "integrated" GP units which began to appear in the mid 1950s. In 1958, the National Survey on Perinatal Mortality suggested shortcomings in the standard of care available in "isolated" GPMUs, and poor results where transfer in labour was required.

In 1959, the Ministry of Health Maternity Services Committee finally adopted the RCOG's recommendation that a national average of 70% of all confinements should take place in hospital. The committee also recommended that all GP obstetricians should have access to maternity beds within "integrated" units. The idea of getting all mothers and babies close to consultant care was progressively finding its way.

The confinement in specialist units did not find favour universally. It met some resistance particularly from the mothers themselves. According to Graham and Oakley (1981) and Stacey (1988), the frames of reference of obstetricians and women differ as to both the nature of childbearing and its context.

"Obstetricians see pregnancy and birth as medical matters, mothers as a natural biological process. The obstetrician has a limited view of the woman as a patient through her pregnancy and until after the birth; for the woman it is not an isolated episode but an event integral with the rest of her life. Her notions of a successful outcome are far more complex than his. These differences lead to conflicts, but the

differential, social positions between them leave the consultant in command. (Stacey, 1988, p. 238).

The protest was expressed through pressure groups, such as the Natural (later to become National) Childbirth Trust (NCT). The NCT was founded to provide education and support for women who wanted to take an active part in the birth of their child. Together with other pressure groups, such as the Association for the Improvement of Maternity Services (AIMS), the NCT campaign against the dehumanising of birth and the "unnecessary" technological intervention in the management of pregnancy advanced. As Summey and Hurts (1986) indicated:

"In recent years, the profession has come under attack by the very women it serves: the medical model of disease and intervention is said to have subsumed and perverted the midwifery model of support and assistance. The last vestiges of social childbirth described by Leavitt (1983) as a women being brought to the bed in her own home by the women she had called together gave way to scientific childbirth characterised by giving birth drugged and alone among strangers in an impersonal hospital. Women, who in the 19th and 20th centuries hastened the medical takeover of childbirth hoping it would save them from "death's door" (Leavitt and Walton, 1984), now resist the medicalisation of their childbirth experiences" (p.134).

The growing criticism of the obstetric profession by women can be associated with the emergence of a wide variety of "new social movements" (Scott, 1990) and, in

particular, to the womens liberation movement. As Stacey (1988) indicated:

"It was a characteristic of the feminist movement of the late 1960s and early 1970s that some women began for the first time to criticise the way in which they were treated by the medical profession; they began to develop the hypothesis that medicine was an active agent of their continued oppression. Reactions of women, not themselves feminists, to their increasingly passive and subordinated role which the new obstetrics forced upon them fuelled these arguments. (p. 242).

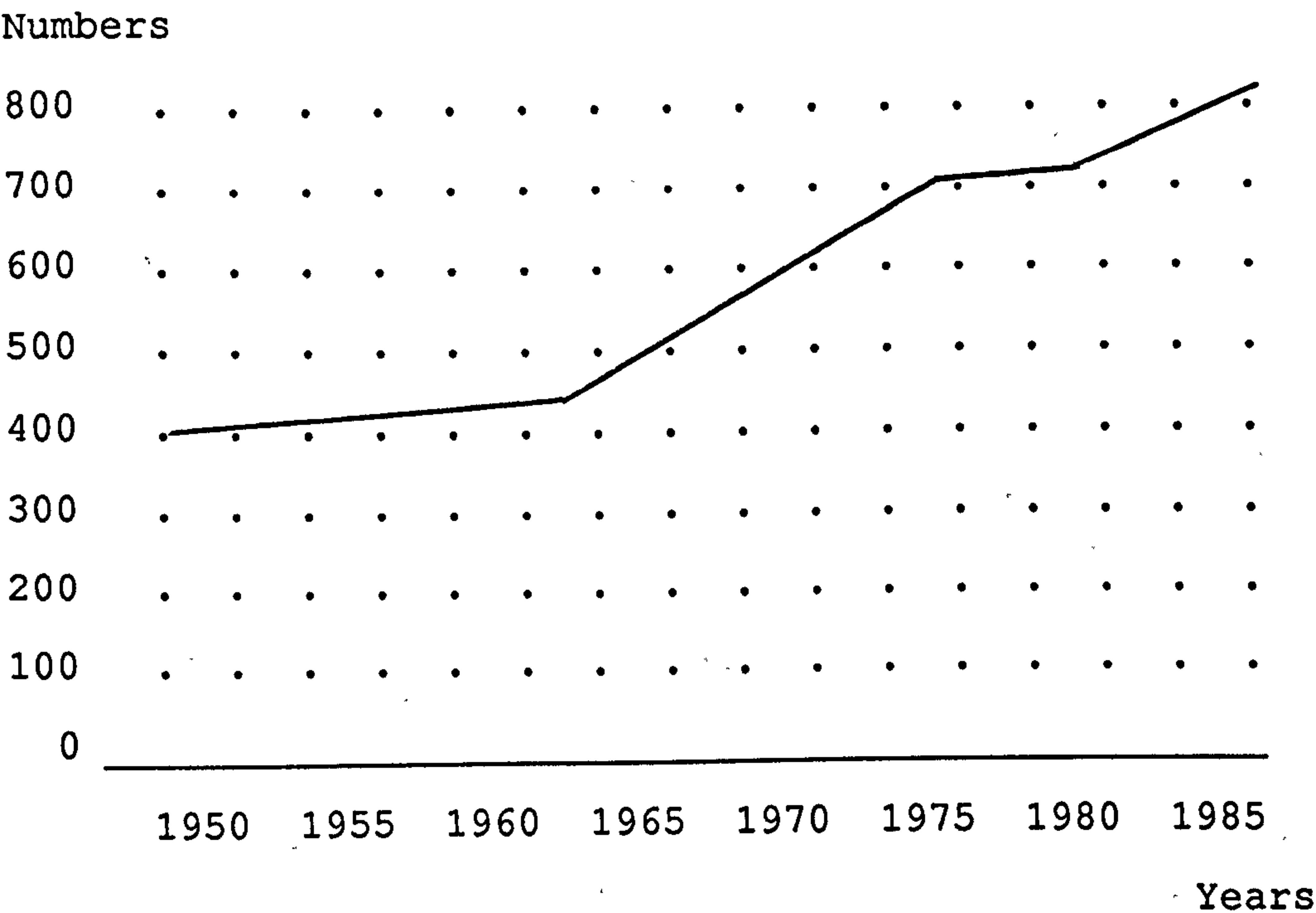
Recent History, Culture, and Context of Maternity Services

The numbers of consultants in obstetrics and gynaecology started rising much more steeply from 1963 onwards than it ever had since the inception of the NHS in 1948 (Figure 5-4).

Figure 5-4

Number of NHS Consultants in
Obstetrics and Gynaecology
England and Wales

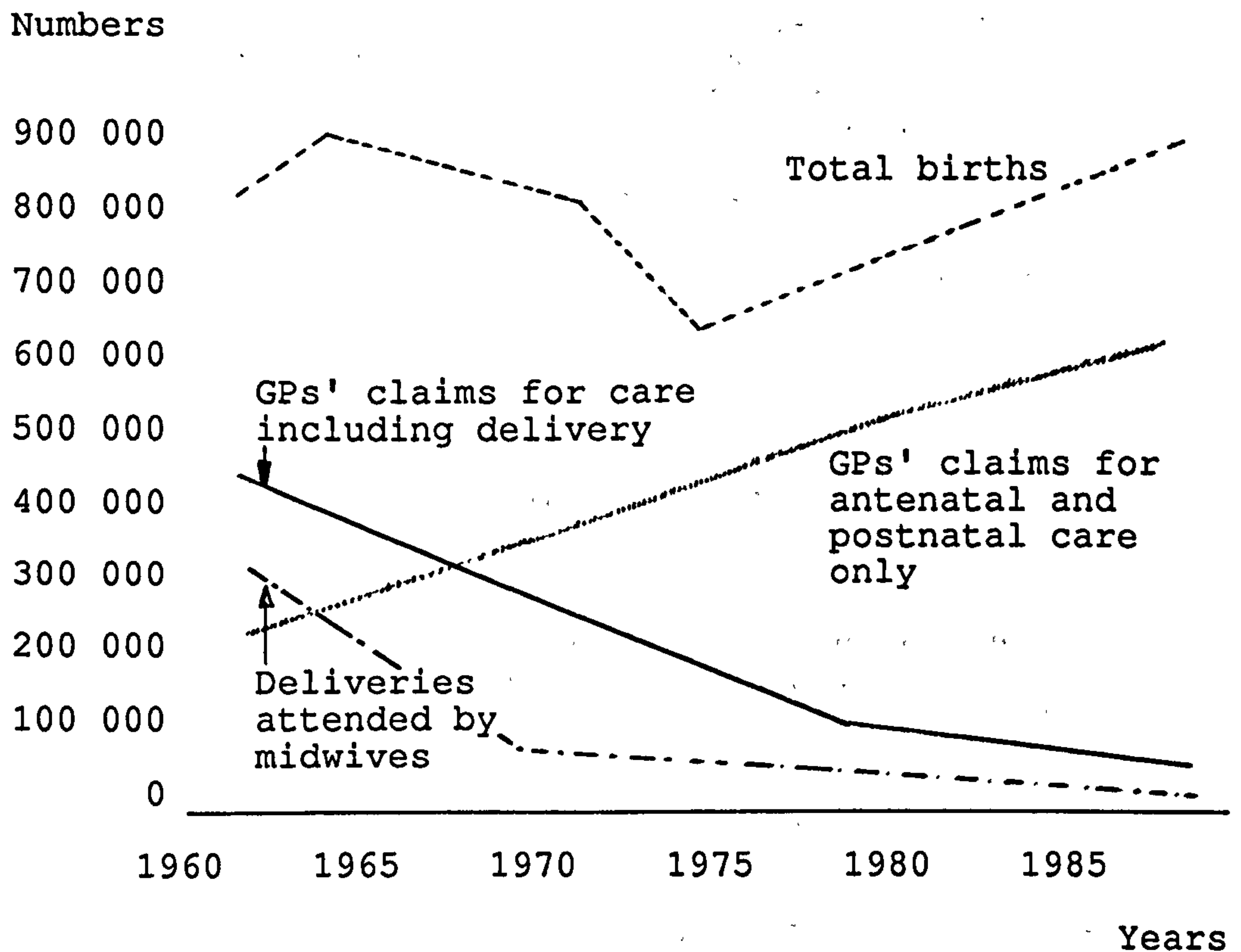
1950 - 1985



Source: Campbell & Macfarlane (1987), p. 16.

From 1965 to 1975, the fertility rate and the number of births fell sharply from over 850,000 to below 600,000. Occupancy levels, particularly in GPMUs, inevitably fell. In the twenty years from 1960 to 1980 the roles of both the GPs and the midwives changed totally from attending deliveries to providing antenatal and post natal care only (Figure 5-5).

Figure 5-5
The Changing Role of GPs and Midwives
England and Wales
1960 - 1985



Source: Adapted from Campbell & Macfarlane (1987), p.21

Both the GPs and the midwives progressively withdrew from intrapartum obstetric care without much resistance. This suggests a tacit agreement, amongst the professions involved, that the change was necessary. It also coincided with an increasing tendency to see pregnancy and childbirth as hazardous

events in which specialist medical assistance and intervention are very often required. As Stacey (1988) indicated:

"This history can be seen as an inter-professional struggle between obstetricians, GPs and midwives in which the first won at the expense of the other two They, GPs, became convinced by the obstetrician's arguments that no delivery can be regarded as safe until it is over, that is that one could not tell in advance what might be a normal delivery and that therefore all deliveries must be regarded as potentially abnormal." (p. 240)

In the 1980s pressures to reinvolve the GPs in obstetrics came from various directions. As March et al (1985) pointed out,

"GPs are now reasserting the advantages of continuity of care in pregnancy and labour and the suitability of GPMUs for patients at low risk. In 1981 the RCOGs and the RCGPs jointly recommended that the number of GPs who provide full obstetric care should be increased. This was restated by the working party of the RCGOs on antenatal and intrapartum care. Patients have begun to react more openly against the dehumanising of birth and the inappropriate use of obstetric technology. Some consultants now recognise the particular skills contributed by GPs in low risk confinement" (p. 901)

The midwives also began protesting about their status and various aspects of childbirth:

"The midwifery leadership had not protested the new developments as they took place. The Association of Radical Midwives, which was formed in 1976, has a programme which would change the division of labour radically. The Association argues that midwives should be responsible for the 80% of normal births;

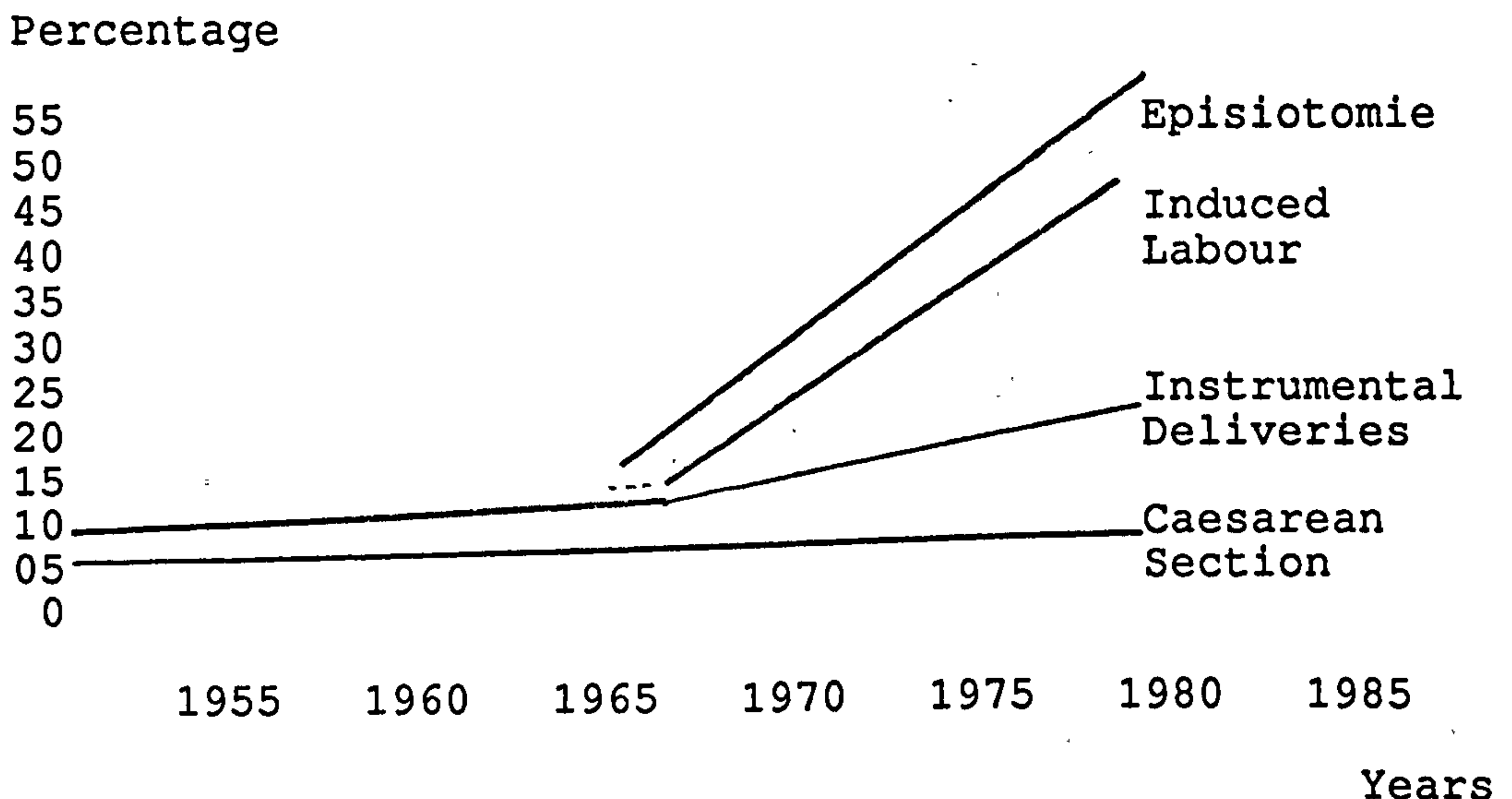
that midwives should be independent practitioners contracting with the NHS as GPs do; that 60% of deliveries should take place at home attended by midwives; that women should have choice of place and manner of delivery (Stacey, 1988, p.241).

The decline in interest by GPs in intrapartum care was commonly attributed to the diminished opportunities to maintain their skills and confidence (Black, 1982; Jewel, 1985; March et al, 1985). The fact that the fall in the GPs' claims for care, including delivery, preceded the closures, and that it occurred mainly at a time when the numbers of GP maternity beds were still increasing, suggests that other factors might also be responsible. For instance, many techniques to assist delivery such as the use of oxytocics and prostaglandins for induction and acceleration of labour, the electronic fetal heart rate monitoring and epidural analgesia were introduced during that period. This added to the trend towards greater technological intervention in labour in both normal and complicated cases (Figure 5-6).

Figure 5-6

Trends in Obstetric Intervention
England and Wales

1955 - 1985



Source: Macfarlane & Mugford (1984), p.161.

At the same time, the development of antenatal technology, such as ultrasound imaging and amniotic fluid analysis, led to a greater awareness of the factors which might call for specialist care at the delivery. This, however, was accomplished without increasing the ability to predict a problem free delivery which would call for GP obstetric and midwifery care.

In the 1960s, the maternal mortality rates reached the theoretical minimum that might be achieved and the emphasis in obstetrics shifted from maternal to perinatal mortality. As Summey & Hurst (1986) pointed out:

"During that period, we saw a shift from a focus on management and childbirth procedures to one of monitoring and surveillance. In obstetrics an integral part of this shift was the change from the obstetrician's focus on the woman patient, or even the reproductive system, to the primacy of the fetus. The fetus has supplanted the woman as the obstetrician's patient. The technological advances of the period, extensively reviewed by Arney (1984) were harnessed to the use of the obstetrician for his in utero patient" (p.112)

By the beginning of the 1970s concern was broadening to include minimising impairments particularly among pre-term and low birthweight surviving babies. The developments in paediatrics, in neonatal care and the advent in the mid 1970s of an effective respiratory support for immature newborn babies, in particular, improved the survival chances for even the most pre-term and low birthweight babies. Policy reports pointed at modern pediatric neonatal intensive care in order to reduce some of the non-fatal but adverse outcomes of pregnancy. This called for the pediatric wards such as in Milton Keynes (Chapter eight) and in Wellingborough (Chapter nine) to be

relocated with the maternity units alongside the main district obstetric ward.

Current Policy: Universal Hospitalisation

In 1970, when maternity policy was reviewed by the DHSS Standing Maternity and Midwifery Advisory Committee, 73% of all births were already taking place in hospitals with consultant obstetric beds and less than 13 per cent of women were delivered at home. Even without specific policy direction the institutional confinement rate was rising sharply from 1963 onwards.

The Committee recommended that maternity accommodation should be provided to allow for 100% hospital delivery and it went on to suggest that small isolated GPMUs should be replaced by larger combined consultant and GP units. It was argued that the greater safety of hospital confinement for mother and child justified such proposals. This allegation has been echoed by a number of committees of inquiry that have since looked at the maternity services, such as the 1978 Parliamentary Select Committee on Social Services. It was hoped that getting mother and baby closer to specialist care and life-saving equipment would reduce further the perinatal mortality as well as the number of babies born with an impairment because of harm at the delivery. In particular, the hazard associated with transferring women during labour to

specialist care in the event of an obstetric emergency was seen as an "unnecessary" risk. According to Stacey (1988),

"Around the time of the Peel Report, the obstetric profession decided that women were not to be permitted to take the risk of having a child at home. They further decided that they should intervene to reduce risks; that women had placed themselves in their hands, and therefore the decisions should be professional ones" (p. 242)

It is not our intention to get into the debate about whether the obstetric wards are safer (Klein, 1985) or are not safer (Tew, 1985) than GPMUs. Table 5-2 presents the crude Perinatal Mortality Rates in both peripheral GPMUs and in NHS hospitals.

Table 5-2

Perinatal Mortality Rate for Babies Born
in Isolated GPMUs and in
other NHS Hospitals

Year	Births in Isolated GPMU	Births in Isolated GPMU as a % of all Births	Nos. of Perinatal Deaths in Isolated GPMU	Perinatal Mortality Rates per Thousand Births	
				GPMU	NHS Hospitals
1975	43 862	7.2	218	5.0	20.4
1976	45 458	7.7	191	4.2	18.8
1977	39 019	6.8	202	5.2	17.7
1978	35 645	5.9	176	4.9	16.1
1979	32 700	5.1	122	3.7	15.0
1980	27 225	4.1	101	3.7	13.6
1981	22 210	3.5	63	2.8	12.0
1982	21 056	3.3	42	2.0	11.4
1983	16 694	3.1	41	2.1	10.5
1984	18 435	2.9	37	2.0	10.2
1985	16 346	2.5	27	1.6	9.9

Source: OPCS Birth statistics.

The problem starts when it comes to interpreting the significance of these statistics. Both sides in the controversy are arguing that the figures support their own view on the issue. Little evidence on the safety of the GPMUs was, however, put forward by the Select Committee to support its proposals.

"The evidence it adduced included as a main plank a table which showed that as the proportion of hospital births had increased, so the incidence of maternal and infant mortality had decreased. In a withering attack on the lack of sound research data on which to base this major and expensive change of policy, Archie Cochrane (1972) pointed out that because two factors co-vary (ie move together) it does not follow that one is the cause of the other.... In the years from 1955-1968 which the Peel Committee surveyed, there had been many other changes: improved housing standards and improved nutrition for example. Although class differences remained, the all round longevity of health of the population had improved. It is likely that some of these factors were also associated with improvements in perinatal and maternal mortality" (Stacey, 1988, p. 239)

Further research failed to provide the evidence requested. As Black (1982) pointed out:

"most studies on the place of delivery and perinatal outcome have been unable to show the clear association between GP deliveries and adverse outcome that has been implicitly accepted by successive governments ... the notion that GP deliveries constitute a risk continues to gain support from national guidelines, expert reports, and opinions of most obstetricians, based largely on belief" (p.490).

Notwithstanding, the recommendations were adopted by the Ministers and implemented almost immediately. In 1978, the delivery at home represented only 1.6% of all maternities and over 92% of all births were taking place in hospitals with a consultant ward, and a large number of small "isolated" GPMUs were already closed (Table 5-3). According to Gray and Hunter (1983) this suggests that a consensus exists throughout the policy chain from national to local levels.

"This can happen occasionally as in the case of the virtual achievement of a policy goal of 100% institutional confinement rate for childbirth. More usually, the periphery is able to thwart, distort or delay if it dislikes particular policy initiatives emanating from the centre" (p.429)

Table 5-3

Number of Peripheral GPMUs per Region
1973-1986

Health Regions (by decreasing size of population)	1973	1978	1983	1986
West Midlands	19	14	10	9 ..
Trent	20	18	13	16 ..
North Western	30	9	5	4 ..
Yorkshire	14	8	6	5 ..
South East Thames	12	6	4	3 ..
North West Thames	2	2	2	0 ..
North East Thames	6	4	6	4 ..
South Western	43	25	25	17 ..
Northern	17	9	7	7 ..
South West Thames	7	2	0	0 ..
Wessex	18	22	17	16 ..
Mersey	5	4	2	0 ..
OXFORD	18	17	13	9 ..
East Anglia	10	8	6	4 ..
TOTAL _____	221	148	115	94

Rationalisation of All Existing Maternity Services

The trend towards closing the GPMUs was given a new impetus by the acute energy crisis of 1973-74 which precipitated the economic recession in England, generated high rates of inflation, and resulted in a series of substantial cuts in public expenditure imposed by the Labour administration during the period 1976-1979 (see Table 5-4).

Table 5-4
Summary of Expenditure Cuts
1976 - 1979

	1976-7	1977-8	1978-9
Announcement (date)	(£m at 1977 survey price)		
1975 budget (4-75)	1347	----	----
1976 White Paper (1-76)	340	2459	3891
July measures (7-76)	27	899	128
IMF cuts (12-76)	---	1617	1557
Total	1714	4975	5576

Source: Bramley, G. and Stewart, M. (1981), p. 41

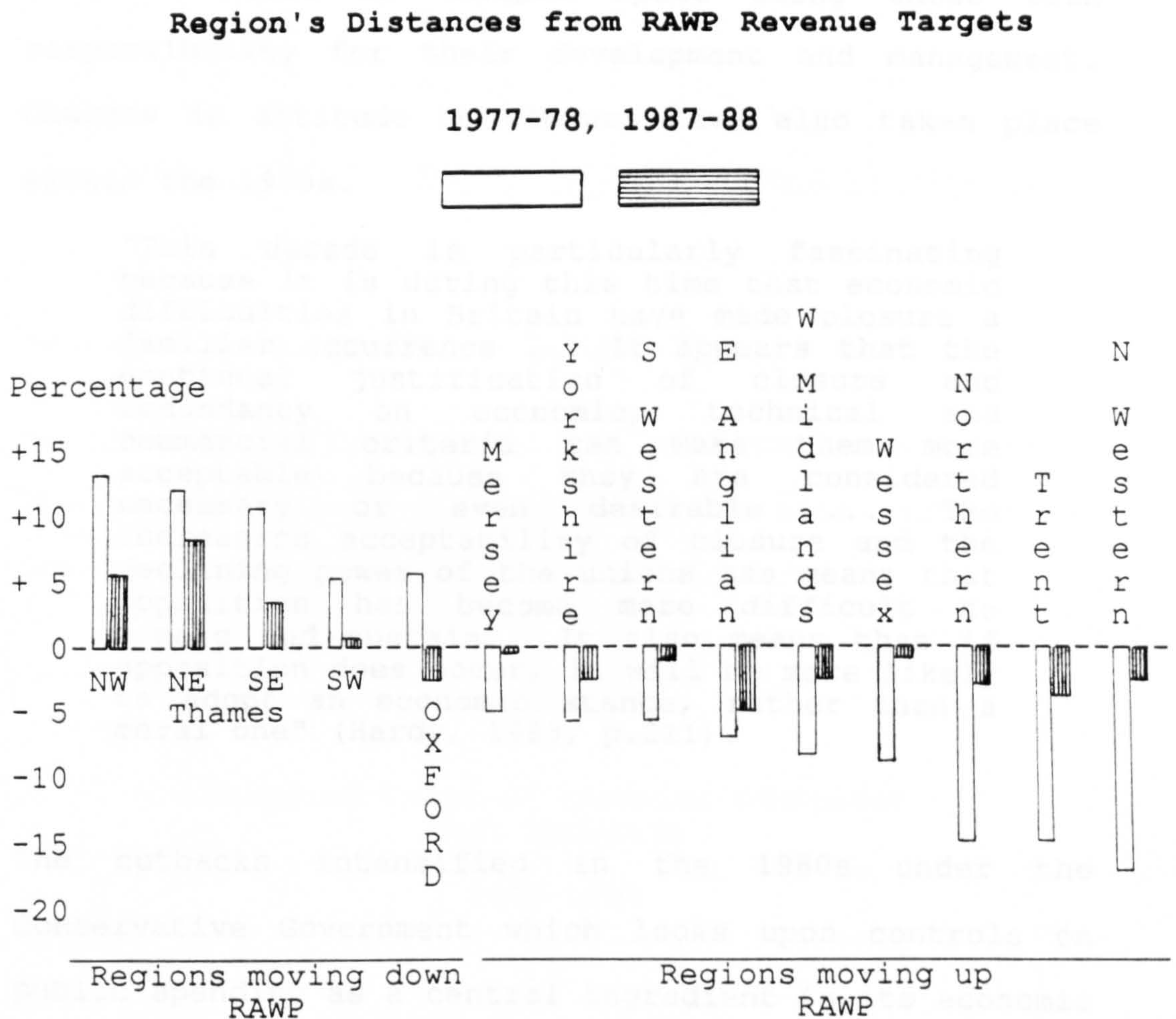
From 1976 onwards, the pressure to rationalise acute and maternity services has increased most in those regions, such as Oxford, moving down towards lower RAWP (Resource Allocation Working Party) targets.

The problem was well summed up by Klein (1985):

"The NHS inherited a geographical distribution of resources heavily biased towards the metropolitan area around London which persisted into the 1970s, when a determined effort was launched to redress the balance. A formula for rationing resources (RAWP targets) was then devised on the basis of demographic factors and mortality statistics. This provides a benchmark for judging whether any given region or district of the NHS is below or above its "equity" target. Thus in 1979 the North East Thames region, which takes in large chunks of London with its heavy concentration of expensive teaching hospitals, was reckoned to be 13 percent above target while North West Region, which takes in tracts of Britain's declining industrial heartland, was estimated to be 9 percent below target. Conceived in the days of optimism about economic growth, the formula has proven something of a political landmine in the era of pessimism about economic growth" (p.44)

The various Regions' distances from the RAWP targets is presented in Figure 5-7.

Figure 5-7



Source: ORHA, Financial Review 1987, p. 10.

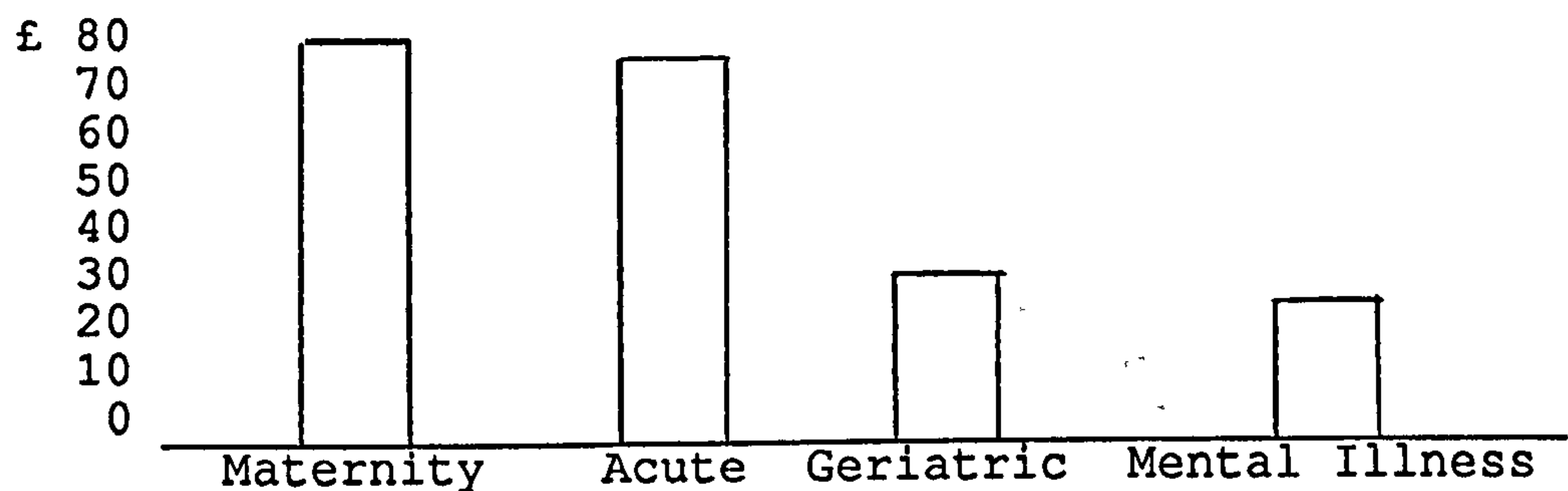
There has been a long-term move for fewer but better equipped hospitals going back to the concept of the DGH contained in the 1962 Hospital Plan. The belief that the centralisation of the maternity services would be cheaper spread among those with responsibility for their development and management. Changes in attitude to closure have also taken place within the 1970s.

"This decade is particularly fascinating because it is during this time that economic difficulties in Britain have made closure a familiar occurrence ... It appears that the continual justification of closure and redundancy on economic, technical and commercial criteria can make them more acceptable because they are considered necessary or even desirable ... The increasing acceptability of closure and the declining power of the unions has meant that opposition has become more difficult to create and sustain. It also means that if opposition does occur, it will be more likely to adopt an economic stance, rather than a moral one" (Hardy, 1983, p.211).

The cutbacks intensified in the 1980s under the Conservative Government which looks upon controls on public spending as a central ingredient in its economic strategy. The maternity departments are the most expensive of the general departments and present an attractive opportunity for rationalisation. The hospital in-patient costs in different units are shown in Figure 5-8.

Figure 5-8

Hospital In-patient Cost per Day
of Various Units



Source: Fry et al (1984), p. 244

In the last fifteen years, the substantial increase in the use of capital in neonatal units also adds to the pressures for rationalisation (Table 5.5).

Table 5.5

Changing Value of Neonatal Equipment
West Midlands

1978-1984

	1978	1984	% change
Unit 1	£ 1 304	£ 6 749	+418
Unit 2	£ 2 028	£ 3 988	+ 97
Unit 3	£ 2 527	£ 6 898	+173

Source: Mugford & Stilwell (1986), p. 58.

As Mugford & Stilwell (1986) pointed out:

"One of the reasons why rationalisation has meant concentration is the fact that some key items of capital equipment, such as operating theatres and a few (but not many) items of neonatal care, come in large indivisible units ... In terms of annuitised costs, medical staffing indivisibilities are more important than those relating to equipment ... A further argument that may be used in favour of large hospitals is that they should cope better with variable demand - that is they should need a smaller reserve of capacity in proportional terms than small units" (p.59)

Since the mid-1970s, the gradual concentration of maternity services within specialised hospital wards has been proceeding under the guidance of the RCOG, aided by a series of committees and reports. In 1976, the Labour Government's consultative document, "Priority for Health and Personal Social Services in England", suggested making the resources of the peripheral maternity units available to other services with more pressing needs. In 1977, the second Labour Government's policy document, "The Way Forward", advocated the closure of small maternity units in favour of large consultant obstetric units based in the DGHs. In 1980, the House of Commons Social Services Committee took on trust the belief that the centralisation of the maternity services would be cheaper and recommended the closure of the small maternity units.

"Although we were not provided with the relative cost of large and small units it seems certain that a policy of closing small units and increasing the number of large units will continue to prove a saving, and even more important, will make more efficient use of the time and trained staff, and expensive equipment" (p.26)

In the 1980s, a number of reports repeated the Social Services Committee analysis. Little evidence, however, was, put forward by the various committees to support their recommendations. As Mugford (1989) indicated:

"In the light of the evidence, the case is not proven that GP maternity care is uneconomic. Indeed, the evidence points to the opposite conclusion. Even so, economic pressures are claimed among the reasons for recommending closure ... The continuing programme of centralisation of maternity units is not based on good evidence about the cost-effectiveness of the policy. There are few studies of costs in GP maternity units, and these all date from a decade ago. The cost effectiveness of GP maternity care is, in any case, a relative concept, and requires evidence of the cost-effectiveness of consultant obstetric care for comparison. This has yet to be studied in any detail" (p.9)

The current debate is obscured by the ambiguous meaning of the concept of savings which is often used to mean cost-shunting. As Korman & Simons (1978) indicated:

"The savings from closure are both real and notional ... The concept of savings as a reason for closure is an attractively simple one; if less is spent on one service, then more ought to be available for others. But it may not always work out this way. If a district is under pressure to reduce costs, then savings on a closure may go towards preventing other services from being reduced;

savings are negative in that the financial situation is prevented from becoming as bad as it might have without the closure, rather than positive, actually having more resources to spend on services" (p. 182)

Patterns of Responses to National Policy

The response to Central government policy has not been uniform throughout the Country. An analysis of the standardised number of closure in GPMUs per million of population reveals four differing strategies used by the various authorities in implementing the central policy (Table 5-6).

Table 5-6

**Standardised Number of Closure of Peripheral
GPMUs per Million of Population in
the British health regions
1973 - 1986**

Region	1973-1978	1978-1983	1983-1986
--------	-----------	-----------	-----------

First Group: The Early Adopters

North Western	5.2	1.0	0.2
South Western	5.8	0.0	2.5
Northern	2.5	0.6	0.0
Yorkshire	1.6	0.5	0.2
South East Thames	1.6	0.5	0.2
South West Thames	1.7	0.6	*

Second Group: The Continuous Adopters

East Anglia	1.0	1.0	1.0
West Midlands	0.9	0.7	0.2
Mersey	0.4	0.4	0.4

Third Group: The Non-Adopters

North East Thames	0.6	(0.6)	0.6
Wessex	(1.4)	1.7	0.3
Trent	0.4	1.8	(0.6)

Fourth Group: The Late Adopters

North West Thames	0.0	0.0	0.8
OXFORD	0.4	1.6	1.2

* : In this Region, all peripheral GPMUs were already closed in 1983.

() : Opening of GPMUs per million of population.

In the first group of regions, labelled the "early adopters" (Rogers, 1983, p.248), the Authorities initially reduced the number of GPMUs sharply and continued to phase them out progressively afterwards.

In the second group of regions, named the continuous adopters, the Authorities have constantly reduced the number of GPMUs throughout the period. The third group, the non-adopters, combines the regions which have increased the net number of peripheral GPMUs during the period. Finally, the fourth group of regions, called the "late adopters", gathers the Authorities which have maintained their peripheral GPMUs for some time before ultimately starting to close some of them. The latter group encompasses the Oxford health region and, therefore, the closure described in the following four chapters.

The discrepancy in the pace of implementation of the policy could result from a large number of factors including different interpretations of the national policy. The closures, however, were often justified by the difficulties in recruiting qualified midwives and nurses. The analysis of the numbers of qualified midwives and nurses employed in maternity departments (Table 5-7) does not support the view that the strategy for closure was primarily determined by staffing

problems; all groups comprise regions with lower or higher staffing levels than the national average.

Table 5-7

**Strategies for Closure and Numbers of
Qualified Midwives and Nurses per 1000 Maternities**

Strategy	Midwives		Nurses	
	1975	1980	1975	1980
NATIONAL AVERAGE ENGLAND	25.2	25.4	15.9	14.6
The Early Adopters				
North Western	29.1	31.3	15.9	17.2
South Western	24.3	22.5	14.0	14.2
Northern	26.0	24.4	18.1	14.8
Yorkshire	22.9	24.9	18.0	7.0
South East Thames	27.1	27.8	16.3	14.8
South West Thames	24.4	24.7	12.2	12.6
The Continuous Adopters				
East Anglia	25.4	25.0	14.9	15.2
West Midlands	23.0	23.4	14.2	16.3
Mersey	22.4	28.6	17.2	18.0
The Non Adopters				
North East Thames	25.1	24.1	17.5	13.9
Wessex	26.5	23.7	13.7	14.6
Trent	25.7	25.2	17.0	17.7
The Late Adopters				
North West Thames	24.2	23.2	12.8	8.3
OXFORD	24.1	24.9	18.6	16.7

Source: MacFarlane and Mugford (1984), p. 207, 215

Implementation of the Policy in the Oxford Health Region

The current Oxford Regional Strategic Plan is the latest in a series of five such plans produced in the region. In the main, the first four plans reflected the National trend for gradual advance in health care on all fronts including maternity services. The fifth Strategic Plan breaks with this tradition. The new strategy echoes the central government policies emphasising prevention and community oriented services, promoting district self-sufficiency in all care groups, and giving greater priority to the services for the elderly, the mentally ill and the mentally handicapped. The shift in emphasis towards the priority groups means a substantial redeployment of resources. In the Oxford health region a reduction of 11% in maternity service expenditure, combined with a reduction of 4% in acute service expenditure, should allow for a substantial increase in the level of resources of most of the other health services provided in the Region (Table 5-8).

The substantial reduction in maternity services expenditure put further pressure on increasing the efficiency of all services provided and on closing peripheral GPMUs in particular. The overall regional strategy with regard to the in-patient maternity

facilities is clearly driving towards the implementation of the National policy.

"There are three main elements of maternity bed provision: consultant obstetric units, GP beds in association with these units, and more scattered elements of GP maternity provision in a number of peripheral hospitals. Regional policy favours the association of GP and consultant units with facility for easy and rapid transfer to the consultant unit should complications arise" (ORHA - Regional Strategic Plan 1984-1994, p.384)

Table 5-8

Financial Implications by Care Group of the Oxford RHA Strategic Plan 1984 - 1994

Care Group	(increased expenditure in % of 1983)		
	Status Quo	New Strategy	Change
	-----	-----	-----
Maternity	+18%	+07%	-11%
Acute	+14%	+10%	-04%
Elderly	+12%	+12%	00%
M.H.	+11%	+22%	+11%
M.I./E.M.I.	+10%	+31%	+21%
Community Serv.	+10%	+31%	+21%
Disabled	00%	+50%	+50%

Source: Elaborated using data from the ORHA (1984),
 "The Region's Health - A New Way Forward".

Table 5-9 details the number of peripheral GPMUs in each of the Oxford DHAs. Between the formulation of the policy in 1970 and the 1974 Reorganisation

virtually no change was made in the provision of peripheral GPMUs by the Oxford Regional Hospital Board. The net number of peripheral GPMUs began decreasing significantly in 1978. The closures have been, however, partly balanced by the opening of a number of new integrated GPMUs.

Table 5-9
Number of Peripheral GPMUs per
AHA and per DHA
Oxford RHA
1973-1988

Areas/Districts	1973	1978	1983	1988

Oxford AHA				
Oxfordshire DHA . . .	6 . . .	6 . . .	5 . . .	4
Northampton AHA				
Northampton DHA . . .	0 . . .	0 . . .	0 . . .	0
Kettering DHA	2 . . .	2 . . .	1 . . .	0
Buckinghamshire AHA				
Wycombe DHA	1 . . .	2 . . .	2 . . .	1
Aylesbury Vale DHA . .	1 . . .	1 . . .	0 . . .	0
Milton Keynes DHA . .	2 . . .	2 . . .	2 . . .	0
Berkshire AHA				
West Berkshire DHA . .	6 . . .	4 . . .	3 . . .	3
East Berkshire DHA . .	0 . . .	0 . . .	0 . . .	0

Total				
Peripheral GPMUs	18	17	13	8
Integrated GPMUs	2	3	4	7
TOTAL GPMUs	20	20	17	15

*: Temporarily closed since March 1987

This concludes the third section of the chapter on the maternity services policy and its changing context. The following section summarises the issues that have been discussed.

Concluding Summary

This chapter has provided the necessary data for a consideration of the implementation of GPMU closure proposals at DHA's level in the 1980s. The first section of the chapter outlined the national political context, the structural context and the bureaucratic process for dealing with closure of health facilities in England. The NHS is a highly sensitive political issue which has been at the core of the national political confrontation throughout the decade. The issue has been seen by the Labour party leaders as the Achilles' heel of the Thatcher's Conservative governments. Local issues such as the closures and change of use of health facilities are, therefore, bound to echo the national controversy over the NHS and to question the government record on its development and management.

A local agreement on closure can be reached by discussion with local authorities, interested parties, and above all with the CHC concerned. The inter-dependency between the DHAs and CHCs is, at the local

level, the key feature of the management arrangement for closure. Negotiation, bargaining, and compromise are, on this basis alone, likely to feature as central elements of the micro-implementation process.

The proposal can be referred for arbitration up the line to the Secretary of State. Because of the delay created by referring the closure proposal and the uncertainty of the Ministerial approval, the DHAs generally favour working out a local agreement with their CHCs before ultimately directing the proposal to the Secretary of State if no compromise can be found.

The bureaucratic procedures for consultation are relatively complex and ambiguous. The failure to comply with the procedures could provide, however, a basis for a challenge in Courts. The successful management of closure requires, therefore, a fair degree of managerial skill in handling and servicing the consultation process according to the particular circumstances and sensitivity of the issue.

The second section of the chapter has presented the formation of the maternity services policy in England, and the context in which it occurred. It has been shown how the changing combination of demographical, epidemiological, socio-economical, technological, medical, and clinical factors have led the policy to shift from universal home confinement to

universal hospital confinement. Changes in the policy have generally been made in a reactive as opposed to a pro-active fashion, meaning that the policy-makers dealt with policy changes only when action could no longer be avoided and when the intended new policy was already well on the way to being implemented.

Probably the most striking feature of the current policy is that it is based on a widely shared belief that the GPMUs are unsafe and uneconomical with little reference to the evidence. As Summey and Hurst (1986) pointed out,

"At the same time, as women lost control over the birthing process, childbirth became much safer for both women and infants. The relationship between the two changes is unclear, and its very uncertainty has played a larger role in the evolution of the professional ideology (obstetrics/gynecology) based as much on belief as on evidence" (p.134)

The absence of clear and unquestionable evidence either to support or to refute the national policy is likely to reflect in the process and outcome of implementation.

For all its oversimplifications, including the tendency to present the formation of the policy as a linear sequential process, the product/service life cycle framework offers an interesting way of

summarising the development of the GPMUs. In the main, the GPMUs followed the following general pattern:

- (1) development in the first quarter of the century;
- (2) growth in the second quarter;
- (3) maturity and saturation in the third quarter;
- (4) decline since the mid 1970s.

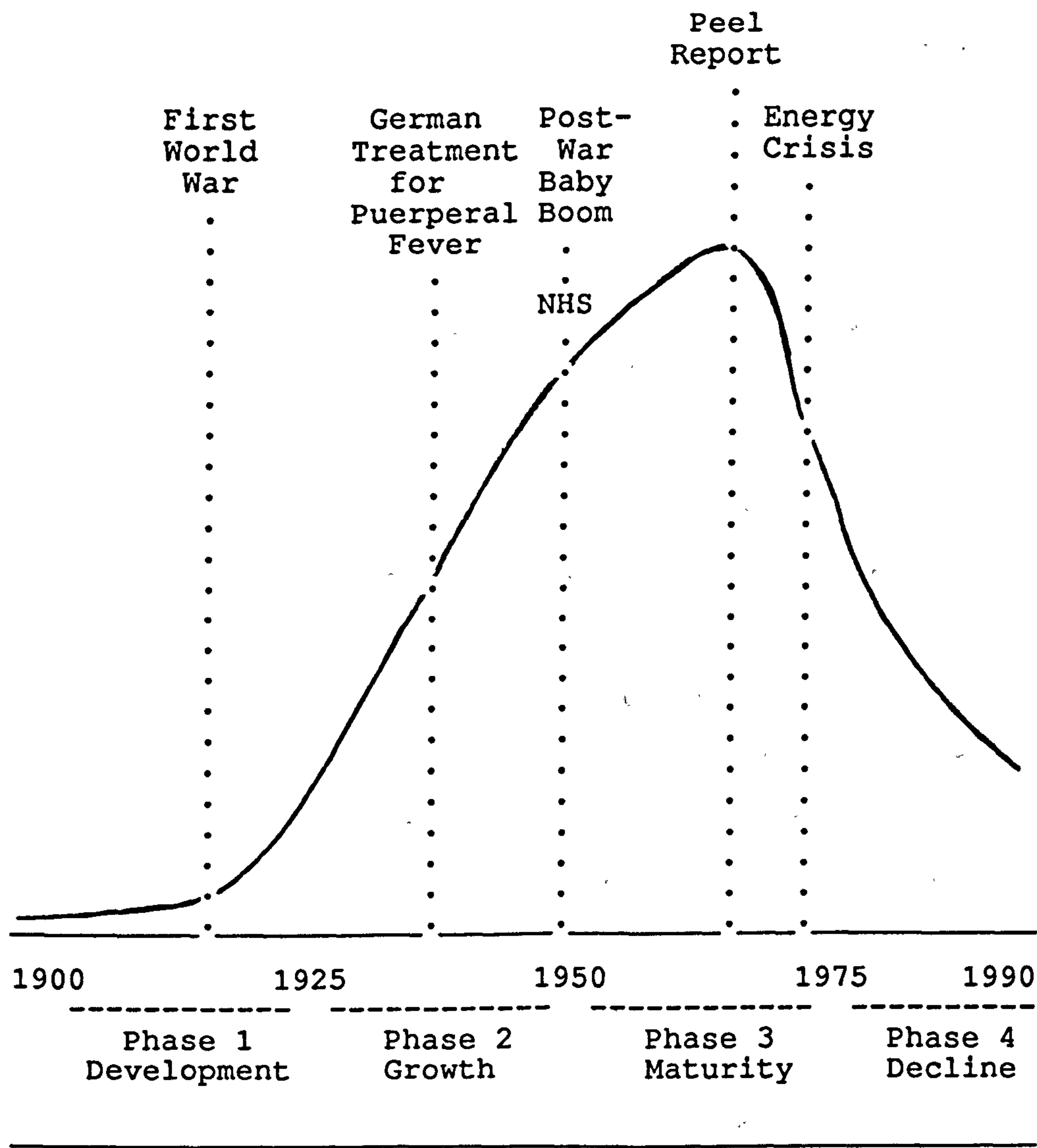
A representation of the GPMUs life cycle is given in Figure 5-9.

Figure 5-9

Key Phases in the Life Cycle of the GPMUs

1900 - 1990

England



In drawing the S-shaped life cycle curve a number of useful dividing lines come forth to break up the sequence. The over crowding of towns caused by the First World War emphasised the need for more maternity homes and led the Ministry of Health to promote, in the post-war years, the provision of such facilities throughout the country. As Campbell & Macfarlane (1987) indicated:

"The risk of maternal mortality did not loom large in the arguments for institutional birth after the First World War. Except for those women deemed to be complicated cases the undesirability for many women's housing conditions was seen as the major criterion. Indeed the focus was on the risks of puerperal sepsis from which death rates were often higher in hospital" (p.25)

One of the major external events which influenced the formation of the policy was the introduction by a German company of an effective treatment for puerperal fever in England. This opened the doors of the obstetric wards to all women in any risk categories. The increasing competition from the obstetric wards combined with a decreasing birth rate inflected the growth of the GPMUs.

The Second World War, the surging demand for health care which followed the inception of the NHS, and the unprecedented booming post-war birth rate, provided the context for a relatively peaceful coexistence between the obstetric wards and the GPMUs.

This reflected in the segmentation of the clientele according to a number of risk factors. As Campbell and Mcfarlane (1987) suggested, it is significant that the current policy of universal hospital confinement advocated in the Peel report - with "integrated" GPMUs being seen as an acceptable alternative, but little support for either the "isolated" GPMUs or for home confinements - came to pass at the end of a period when a substantial increase in the number of consultant obstetricians as well as in the number of maternity beds coincided with a declining birth rate. These circumstances were similar to those prevailing in the 1930s when external pressure for better obstetric care and internal pressure to raise the status of the profession resulted in a move to close the ranks and to question the safety of the GPMUs. As Summey & Hurst (1986) pointed out:

"In both periods we watch the profession (obstetrician/gynecologist) blame others, become defensive, and then quietly close rank to become even more specialised and clinical than previously" (p.112)

Finally, the energy crisis of 1973-74 helped create inflation which resulted in a series of substantial reductions in public expenditure. The spending cuts in the NHS gave a new momentum to the rationalisation of all maternity services and to the

closure of the peripheral GPMUs in particular. As Mugford & Stilwell (1986) indicated:

"There can be no doubt that small maternity hospitals are uneconomic from the health service point of view if they are run and staffed as independent hospitals, and this accounts for the speed with which units are now being closed" (p.64)

Hence, in summary, throughout these years central government policy for maternity services, and especially the policy for GPMUs, has been changing with its changing context. Political and socio-economical changes intermixed with specific clinical changes creating a complex environmental situation to be interpreted by the national policy makers as well as by the local managers, the health care professionals, and the public.

External factors add pressure, and influence the timing of the changes in the policy. While certain shocks, or sudden events, did at times take place, most of the changes were not radical but incremental. They developed slowly, gradually affecting the policy but generally not in a clear, straightforward manner. Although incremental, the process of change has not been continuous but interrupted, sometimes precipitated and sometimes slowed down by a number of major environmental disturbances.

The third and final section of this chapter has highlighted the gap between current policy and its implementation in some of the British health regions. Long-term trends and changing policies in the maternity sector have created a general pressure for the DHAs to change their maternity services and facilities strategy. Literature aimed specifically at studying the link between general environmental stimuli and strategic response is rare (Taylor, 1982; Whittington, 1989). It is, however, thought to be a complex one, particularly if it concerns retrenchment in the public sector (Pettigrew and Ferlie, 1989). The important point is that the DHAs have a considerable degree of choice at their disposal with respect to the timing and strength of their response, especially as the issue has not resulted in specific constraints. Compared with other health districts in England, the Oxford districts have been late 'in closing down their peripheral maternity units. This suggests that the general pressure for closure did not affect all DHAs in the same way and that there was a configuration of features which was not consistent with a straightforward and speedy implementation of the policy in these Districts.

This chapter has outlined the changing policy context. The following four chapters present the case-studies, analysing the evidence and highlighting the

key factors and features which can be associated with the success and failure of implementation.

CHAPTER SIX

Amersham GP Maternity Unit

Chapters six to nine form the empirical core of this study. The chronological, descriptive reconstruction of the closures are presented with as much richness of detail as the available data permit. These chapters have a broadly similar structure. They are organised into four sections. The starting point is a description of the profile of the district and unit under study. This is followed by an overview of the process and outcome of the closure proposal. The next section considers the genesis, development, and conclusion of the closure process. Finally, the concluding section presents an analysis of the case and emphasises the key factors and features which influenced the pace and outcome of implementation.

This chapter documents the progress of two successive proposals to close the GPMU at Amersham General Hospital (AGH) by Wycombe District Health Authority (WDHA). The first proposal concerns the closure of the whole General Practitioner Maternity Unit (GPMU). It was opposed by the Community Health Council (CHC) and rejected by the Secretary of State. The second proposal concerns the closure of the delivery service and the relocation of some post-natal

beds on the AGH site. The CHC decided not to oppose the second proposal and the closure was implemented. Staffing problems combined with financial pressure and the post-natal beds were not reopened.

The Profile of the District and Unit Under Study

The District covers a rather compact area in the South of Buckinghamshire. It has the second highest population density in the Oxford Region yet retains a predominantly rural character. The District includes High Wycombe as well as other less important centres of population such as Chesham, Amersham, Chalfont St Giles, and Chalfont St Peters. Amersham is the North terminal station of the metropolitan line of the London Underground.

In 1983, the population of the District was over 273,000. Wycombe's population had increased only marginally since the beginning of the 1970s and was expected to increase significantly less than any other district in the Region over the planning period 1984-1994. The increase was estimated at about 1% against the Regional average of nearly 11%. This compared to an increase of 2.5% in the population of England as a whole over the same period.

A study of the economic indicators of well-being reveals the District as outstandingly prosperous in relation to the Region and, indeed, to the country as a

whole. The overall standardised mortality ratios (SMRs) indicates that the population of the District is among the healthiest in the Region. The District has as much as 12% fewer deaths than would be expected from the age/sex structure.

Wycombe has the second lowest ratio of acute in-patient beds in the Region. This was necessarily reflected in the service provided. By making a virtue of necessity it has the lowest average length of stay and the highest district performance in respect of day care services in the Region. The District sets the regional standard in treating twice as many acute admissions as day cases as a proportion for the Region as a whole.

Normally such an area and population would look to one central hospital to provide its major health services. By an accident of history, the District has a single DGH, based on a split site Wycombe GH (362 beds) and Amersham GH (250 beds) with three supporting peripheral GP Hospitals mainly providing care for the elderly. The two DGH sites are located roughly eight miles apart.

"The context of that is quite important. In the 1960s there was an opportunity to have one big DGH in Ayslemere just half-way between Amersham and Wycombe. That chance was lost because each town wanted to develop its own hospital and this district has suffered ever since for having two DGHs

within quite short distance each wanting to be THE hospital".

DMT Member

The WGH site dominates the AGH one.

"That is a central fact that one has to understand about the District. At the outset the idea was to have two hospitals. Gradually it became apparent, particularly with the lack of funding in the 1970s, that it was not going to be possible. Although we talk about having a split DGH - half of it being at Amersham and half at Wycombe - reality has been that the DGH has been in Wycombe and Amersham has been fighting an absolute battle the whole of that time to try to retain the services"

Ex-Chairman DHA

The previous public mobilisation around health care issues had left a network of people and groups competent and willing to effectively oppose the first closure proposal. This source of power was successfully mobilised by the opponents to the first closure proposal.

The Wycombe GH site is, for practical purposes, saturated. Further expansion of the hospital is very much dependent upon land adjacent to the hospital being acquired, but the price of this land is estimated as being prohibitive. There is some limited potential for development on the Amersham site. However, up to June 1987 when the enabling work for the redevelopment of the Amersham GH began, new services had to struggle against established ones to get some room and resources

on the sites. This constraining factor in developing services played a critical part in the genesis of both proposals to close the GPMU.

"One key issue was the many claims for the limited space at Amersham"

District Administrator

The strategy of development of acute and priority services pursued by the District since 1965 can be divided into four main periods:

- (1) 1965 to 1969, a period of expansion of acute service based on the development of Wycombe General Hospital (WGH) site;
- (2) 1970 to 1976, a period of rapid rationalisation of acute services particularly on Amersham General Hospital (AGH) site;
- (3) 1977 to 1984, a period of progressive expansion in priority services throughout the District;
- (4) 1985 to 1990, a rapid change of pace towards self-sufficiency in the field of the Mentally Infirm (MI), the Mentally Handicapped (MH), and care of the elderly, with new purpose-built in-patient facilities provided on AGH site.

The 1977 to 1984 period featured serious financial pressure:

"There was terrible financial restriction. There was nothing we could develop. I mean a lot of plans were made but nothing much was done. We were strongly advised by the Region not to expect any growth in resources. Many much needed developments were possible only by withholding developments in other areas or

achieving greater efficiency in the existing provision of services"

DMT Member

The District is currently moving rapidly towards achieving self-sufficiency in Mentally Infirm (MI), Mentally Handicapped (MH), Elderly, and Elderly Mentally Infirm (EMI) services. However, the timetable provides for relatively little change in the provision of in-patient services before the end of the 1980s. Meanwhile the District is reorienting and building up its community services. These ingredients form the framework within which the proposal to close the GPMU was managed.

The Management of the District

From 1974 to 1982, the District had experienced virtually no change on the District Management Team (DMT). The only senior officer who left the DMT during that interval was the District Nursing Officer (DNO) who retired in 1980.

The April 1982 reorganisation brought a very radical change in the DMT. This played a substantial part in the genesis of the first closure proposal. The District Administrator (DA) and the Treasurer retired to be replaced by two newcomers. Furthermore, the two practicing clinician representatives on the DMT were replaced. The hospital consultant who succeeded on the

DMT was the principal consultant obstetrician at WGH. This take-over played a critical part in the transfer of the Shruberry Maternity Home to WGH and in the genesis of the first formal proposal to close Amersham GPMU.

The District Community Physician (DCP) died at the outset of 1983. His successor joined the DMT to undertake the work on the District Operational Programme. Therefore, continuity at the DMT level was provided by the Nursing Officer alone.

An interesting dimension to this case-study is that it reports the genesis, development, and conclusion of two consecutive closure proposals. The first one immediately preceding the Griffiths' report, the second one following soon after. The managerial style of the District following the implementation of Griffiths shows a striking difference in comparison to the managerial style which preceded it. The change of personalities and style altered the balance of power for and against the closure proposals (Pettigrew, 1985).

Before the implementation of general management, there was no formal leader of the District Management Team (DMT). The chair of the DMT was rotated annually. At the time that the first closure proposal was issued,

it was held by the DA who had been the late Area Health Authority (AHA) Administrator.

Commenting on the consultation document, the DA summed up his own managerial style as follows:

"It was all there for people to read. If people like to read more into it, that is up to them. I am a natural bureaucrat. I like to see everything in print and writing".

District Administrator

The DA's distinctive bureaucratic skills granted him the status of an extremely meticulous administrator among his fellow DMT members. These skills were also acknowledged by the Secretary to the Community Health Council (CHC) as well as by the District Chairman:

"The District Administrator was a man who abided by his regulations. He was a very meticulous man, very much an administrator, not much of a politician"

ex-Chairman DHA

The Chairman was a barrister. In the mid-1970s, he was a member of the AHA and, later, became a member of the Oxford Regional Health Authority (RHA). He was the first Chairman appointed since the elevation of the District to authority status in 1982.

The Chairman used to sit in on the DMT meeting. That particular involvement of the Chairman was far from unanimously welcomed by all the DMT members. He

was seen by some of the DMT members as an autocratic chief executive.

As the publication of the first District Operational Plan illustrates, the communication between the Chairman and the DMT was muddled.

"I was on holiday in China. When I came back I found that the whole district plan had been published for consultation. I was rather cross".

ex-Chairman of the DHA

The responsibilities of the DMT members were confused but the main criticism addressed to the DMT was its diffidence to disturb the equilibrium of the situation. The DMT's style was "laissez-faire".

"The responsibilities of the various members of the DMT and the responsibility of the Chairman in particular were not clear ... No one had the strength to say to the Chairman that he should not come to the DMT meetings. Nobody wanted to rock the boat".

DMT Member

The District managerial style following the implementation of the Griffiths' report contrasts with the description above. The current DHA Chairman was nominated in 1986; he is an accountant. He has a strong industrial background which he sees as a strength in the present climate:

"People do not like talking about treating their bodies in the same context as building a motor car but actually it is exactly the same ... You have got to remember this

business is no different from running any factory. It is relatively new to talk about the health service in terms of value for money, investment return, and good resource utilisation. It is no different at all ..."

DHA Chairman

The present Chairman's relationships with the trade unions and the consultants are particularly good and he has the commitment of all the members of the Senior Management Group (SMG). The SMG took over the DMT following the implementation of general management in 1985.

"He works hard for us. He obviously enjoys it and that comes across and it is infectious"

Unit General Manager

He is regarded by most SMG members as a fine communicator and a skilled politician.

"His style is much more "work behind the scenes" while the previous Chairman was much more "I will push it through myself"

District Nursing Officer

The District General Manager (DGM) came on the scene in 1982 as the Treasurer. His appointment as DGM was made in 1985 by the previous Chairman of the Authority. The Treasurer was selected despite strong pressure from both the Department and the Region to appoint someone from outside the District. The disagreement between the District, the Region, and the

Department was resolved by the intervention of the Minister.

"Two consecutive selection committees were unanimously in favour of the appointment of the Treasurer as the DGM. However, the Department as well as the Chairman of the RHA were still very keen on having external candidates. As the Chairman of the Authority, I exercised my prerogative and I went to see the Minister who approved the appointment"

ex-Chairman of the DHA

The DGM favoured incrementalism in implementing change.

"Unlike other districts in the Region, the DGM has set up his units on a geographical base as opposed to a service base. This is less threatening to this district. While it could be criticised for setting up an organisation which seems to be based on buildings rather than services, he has created a lot of much needed on-going stability. Gradually we are moving towards an acute and priority services type of management in the District"

Unit General Manager

He has a specific vision of the District's long term direction and favours decision made by committees involving the managers concerned. Because of his background as a Treasurer, he is particularly sensitive to the district's financial condition.

"We are very conscious of money in the District. I do not mean that we are mean but there is not a lot of profligacy or overspending going on".

Unit General Manager

The Profile of the Unit Under Study

The birth and development of AGH is typical of most small hospitals in England. First known as the Amersham Union Workhouse in 1838, it was renamed the Amersham Public Assistance Institute in 1930. An Emergency Hospital was built on its site during the Second World War. At the end of the war it assumed the title of Amersham General Hospital (Salmon, 1988).

A brief review of the recent history of the Hospital provides an opportunity to sketch some of its prominent historical and cultural characteristics. These features make up the backcloth of the case-study.

The AGH has had a long tradition of pioneering work in Paediatrics. In 1952, a system was introduced whereby mothers were allowed to stay with their children while in Hospital. The children who benefited from this scheme had a shorter recovery period. The idea caught on in children's wards across the country as well as abroad and in 1967, one of the pioneers, Sister Ivy Morris, was awarded an M.B.E. for her services to children. The tradition was important in hindering further proposals to close the Paediatric ward.

"From time to time we did look at the possibility of centralising Paediatrics. That frequently came up not only as a cost saving measure but as something desirable from the service point of view. We never had the courage to tackle that. At the time

when the people remembered the main paediatrician and his colleagues it would have been very difficult indeed to close the Amersham Paediatric services"

DMT Member

The closure of the Amersham GPMU was initially planned to take place at the same time as the closure of the Paediatric ward. This created a particularly emotional situation in Amersham. Public opposition focused primarily on saving the Paediatric ward.

In the early 1960s Amersham struggled to avoid the centralisation of health services on a half-way site between Amersham and High Wycombe. The fight against the centralisation of the health services was still very much in people's minds when the proposal to close the GPMU was initially mooted in 1983. The Town Council public assembly which discussed the first closure proposal was convened "to avoid the centralisation of the two hospitals". The myth that the future of the acute services at AGH were under threat was widely accepted in the local community.

The hill between the two towns was seen as an important natural barrier, particularly by the local politicians and the CHC members.

"There is no natural link between Wycombe and Amersham. They are very different places but apart from that it is the geographic barrier of the hill. They are two separate communities"

ex-Secretary to the CHC

In the late 1960s, the AGH assumed the entire burden for acute care within the district, whilst the neighbouring High Wycombe War Memorial Hospital was demolished to be replaced by the new Wycombe General Hospital (WGH). The AGH won high praise within the local community for providing the health care services for the whole district. That contributed to consolidating the belief that Amersham should have been chosen as the single DGH site.

In 1970, the Oxford Regional Hospital Board (ORHB) indicated that the plan for the development of hospital services provided for the AGH to be developed as a general hospital complementary to the new WGH. Despite major capital investments and various upgrading work carried out at the AGH to keep the wards in effective use, the fabric was in a worsening condition.

In 1973, the DHSS announced a substantial scheme to undertake a complete redevelopment of the hospital. It was proposed to develop the AGH to provide 400 beds incorporating facilities for acute care, care of children, the elderly and the Mentally Infirm. Unfortunately, the unfavourable economic climate of the mid-1970s led to the shelving of this scheme. The dominant district operational aims became building up the levels of provision, and encouraging the most

rational location of facilities. This setback upset the local community who, from this time onwards, feared for the future of its local hospital. Notwithstanding, a suite of brand new operating theatres was opened at the hospital at the end of 1983.

In the mid 1970s, the 35 consultant obstetric beds were transferred from AGH to the new WGH obstetric and Gynaecology Department.

"The history is important. When I came here in 1962 the main consultant ward was in Amersham Hospital. There was another small GP unit near Amersham, the Stone Maternity Home. There was no obstetric services in Wycome but the Shruberry Maternity Home which was a GP unit with no resident doctor. That continued until the WGH unit was built in 1976. Then the role was reversed. WGH became the main consultant ward and Amersham became a peripheral unit"

Consultant Obstetrician

Because the AGH had been for many years the centre of obstetrics, a large proportion of the local population was born or had given birth at Amersham. The personal experience of these people did not match the claim made by the obstetricians at Wycombe DGH that the maternity unit at Amersham was unsafe.

The 1970s also saw the closure of the AGH Casualty Service. This was fiercely opposed, particularly by the District Council and the local CHC.

"There was a very strong move by the Health Authority to transfer all acute care from Amersham to Wycombe. The Authority would have

let Amersham Hospital run down into a geriatric hospital if land had been available for expansion on WGH site to concentrate all acute care there. The people of Amersham have a huge affection for that hospital and anything related to it. They would resist to the death any attempt to transfer further service to Wycombe"

ex-Secretary to the CHC

The two hospital site drama, the shelving of the redevelopment plan for the hospital coupled with low capital investment and with the progressive closure and transfer of acute services toward Wycombe built up hostility from the local Councils and antagonism from the CHC.

"I inherited the feeling of antagonism from the Secretary of the Council. She was quite prepared to take an antagonistic role. Amersham has always felt under threat and the CHC always saw part of its role as defending Amersham"

Ex-Chairman of the DHA

The GPMU was the latest addition to the list of services provided at AGH. The services which were carried out at the Stone Maternity Home (SMH) in Chesham were transferred to the AGH on the 28th May 1976. This marked the opening of the Amersham GPMU.

The proposal to close the SMH was initially put forward, in March 1973, by the Regional Hospital Board (RHB). The building occupied by the SMH had to be demolished to make place for a new County Council road

development. In the circumstance, the RHB felt that the normal closure procedure for closure involving a formal round of consultation was needless and purposeless. In January 1974, after months of discussions between the Board and the DHSS, the Secretary of State, Mr Wafer, did not accept the Board's arguments and requested the Board to undertake the normal consultation procedure.

In April 1974, as a result of the NHS reorganisation, the Area Health Authority (AHA) took over the responsibility for closure and, following a recommendation from the Health Care Planning Team, undertook the consultation. Despite strong opposition, particularly from the GPs' Surgery which was providing general medical cover for the patients of the Maternity Home, the newly established CHC did not object to the closure proposal provided that beds were made available at the nearby AGH.

The provision of GPs beds at AGH was intended to placate the local community and authorities:

"We had just transferred the obstetric service from Amersham to Wycombe. This disturbed the feeling of security at Amersham. The closure of the Stone Maternity Home was strongly opposed particularly by the GPs. In this context we produced a peace offering: we transferred the maternity services from the Stone Maternity Home to the general hospital in Amersham. We thought the new maternity unit at Amersham would benefit from the hospital's good reputation in

obstetrics and keep a high level of bed occupancy"

DMT member

The Amersham GPMU had 10 beds and 1 labour ward. On average, 70% of the admissions were post-natal discharges from the DGH. The number of births over the period 1977-1982 rose from 207 to 234 and then fell to 150 (Table 6-0). An important feature is that the Amersham GPMU's occupancy rate and turnover interval were among the best in the Oxford Region.

Table 6-0

Obstetric and GP Maternity Vital Statistics
Wycombe DHA, 1978 - 1982

	1978	1979	1980	1981	1982
<hr/>					
<u>% beds occupied*</u>					
WGH	83	84	85	84	76
Shruberry	54	59	51	51	37
Amersham	78	83	81	77	61
<hr/>					

Discharges

WGH	2672	2970	3035	2920	2988
Shruberry	1073	1217	1121	1169	872
Amersham	656	701	700	646	534
<hr/>					

Length of Stay

WGH	5.50	5.00	5.00	4.00	4.60
Shruberry	3.90	3.80	3.50	3.30	3.20
Amersham	4.60	4.70	4.50	4.60	4.20
<hr/>					

Births

WGH	2139	2422	2433	2402	2369
Shruberry	481	533	460	478	372
Amersham	207	206	234	169	150
<hr/>					

* Number of beds: WGH: 49, Amersham: 10, Shruberry: 21.

Source: Hospital Statistics 1978 - 1982, ORHA.

The District had another peripheral GPMU: the Shruberry Maternity Home (SMH) in Wycombe. In 1983, the SMH was closed. The maternity home was integrated into the consultant obstetric unit at WGH and became the WGH Shruberry Ward. The integration of the SMH to the WGH obstetric unit carried along a reduction in the number of beds, from 21 to 15. Nevertheless the CHC, and its Chairman in particular, supported it in principle. Some RHA Planning officers were of the view that any such move would require formal consultation. The Secretary to the CHC also felt that normal procedures should be followed and that formal consultation should take place.² However the Area Administrator who in 1982 became the District Administrator, disagreed. No consultation document was produced. As a result of this transfer, the Amersham GPMU was the last peripheral unit still in use in the District.

This concludes the profile of the district and unit under study. The next section presents an overview of the process and outcome of the two proposals to close the Amersham GPMU.

The Closure of Amersham GPMU: An Overview

As Pettigrew (1985) points out, it is often difficult to establish precisely when change processes begin in large, complex, organisations. By the time the

closure proposal was formally put forward, in September 1983, there was already a relatively long history of deliberation about its feasibility.

The initial proposal concerned the closure of the whole GPMU and was contemplated concurrently with the closure of the Amersham Paediatric ward. The announcement of these closures was made public through the formal consultation over the first District Operational Programme, produced under the new NHS planning system which required a much greater degree of consultation at local level in the planning of the services. The DHSS had two sets of guidance on consultation; one on the strategic and operational plans and the other on the closure and change of use of health facilities.

The closure proposals came very much as a shock, particularly to the General Practitioners (GPs) who were using the facilities. Concern was immediately expressed by many local groups and an opposition committee known under the acronym CAWS - Campaign Against Ward Shutting - was set up by two residents.

After considering the public uproar, the Authority promptly withdrew the proposal to close the Paediatric ward, pressing on with the remainder of the Operational Programme and in particular with the proposal to "transfer" the GPMU from Amersham to Wycombe. In order

to allow for remedial work to be carried out to the fabric of the building, the GPMU was temporarily closed.

The GPs, in coordination with the CHC, the local Councils and the public groups, carried on their campaign. The district was a Conservative strong hold. The Amersham MP, Sir Ian Gilmour - "the Tory left wing's most eloquent protagonist" (Holmes, 1985, p.19) and the Lord Privy Seal in the initial 1979 Conservative Government Cabinet - proffered his support to CAWS. The consultant obstetricians at WGH questioned the safety of keeping such a unit open and supported the DHA proposal.

At the end of the consultation period on the Operational Programme, the greatest volume of comments received was on the GPMU closure proposal. At the DHA meeting an amendment that any discussion on the proposal be deferred for twelve months was lost by 10 votes to nine, the Chairman exercising his casting vote against the amendment. This caused a further impetus in the opposition movement.

The DHSS circular on the closure of health facilities specifies that, under normal circumstances, a full consultation is required. Therefore, the Secretary to the CHC inquired about the District's intention to issue a consultation document on the

specific proposal to close the GPMU. The District Administrator, on behalf of the Chairman and the DMT, indicated that the Authority had no intention of doing so.

The main effort of the opponents went into publicising the Authority's failure to comply with the DHSS formal consultation procedure for closure on the one hand, and the relatively good safety record, high occupancy rate, and turnover interval of the Amersham GPMU on the other.

The DHA sought to correct its failure to comply with the DHSS circular on closure by holding a series of meetings with the persons and agencies concerned. After having rejected the CHC counter-proposal to relocate the unit elsewhere on the AGH site, the DHA referred the whole matter to the Regional Health Authority (RHA).

The RHA agreed to support the DHA plans to close the Amersham GPMU despite the District having contravened the normal closure procedure and forwarded the proposal to the Secretary of State for a decision.

Five months later, the decision that the Amersham GPMU should be re-opened was announced by the Secretary of State, Mr John Patten. Approximately two years after its temporary closure and the initial proposal for permanent closure, the Amersham GPMU re-opened on

3rd June 1985. It was between the DHA and the RHA that the performance of the unit would be closely monitored.

The second proposal to close the Amersham GPMU was mooted only seventeen months from its re-opening. It concerned the closure of the delivery service and the relocation of five post-natal beds in a redesigned and refurbished ward on the AGH site. It was proposed to develop a new District Rheumatology/Rehabilitation Unit (RRU) in the old maternity building, providing alternative accommodation for the maternity services. The proposal was made following a detailed informal consultation with the CHC, the DHA advisory committee and staff representative, and an evaluation of the performance of the Amersham GPMU since it had re-opened.

The formal announcement of the closure proposal was made in a consultation document titled "Development of Services at Amersham General Hospital". A large proportion of the consultation document was related to the development of the RRU.

There was strong support for the provision of a RRU. The opposition to the closure of the delivery suite at Amersham was disunited. The GPs, although sorry to see the facility disappear, did not actively object to the proposal, whilst the CHC supported the proposal as a total development. The National

Childbirth Trust (NCT) was the principal leading opponent to the closure proposal.

The Amersham GPMU delivery facilities closed on 1st March 1987, less than four months after the inception of the formal consultation. In January 1988, the new out-patient facilities were ready for them to move into but unexpected staffing problems, combined with financial pressure, meant that the unit stayed temporarily closed. It has not yet been re-opened. Table 6-1 presents the diary of the main events leading to the conclusion of the closure processes.

Table 6-1

**Amersham GPMU Case-Study
Diary of the Principal Events**

First Proposal - Transfer of the Whole GPMU

- | | | |
|-------------------|---|---|
| 1982
November | - | District Review Meeting
The District should examine ways and means of rationalising its physical estate. Review of the District maternity services by WGH consultants. |
| 1983
September | - | Announcement of the proposals to close the whole GPMU and the Paediatric ward through the formal consultation over the Draft Operational Programme 1984-1985. |
| November | - | Withdrawing of the proposal to close the Paediatric Ward |
| December | - | Approval of the District Operational Programme |
| 1984
January | - | Refusal to issue a consultation document on the specific issue of closing the GPMU. Break with the formal DHS procedure for closure |
| | - | The CHC resolved to oppose the proposal. |
| February
March | - | Attempt to remedy the initial lack of consultation over the closure proposal |
| | - | Rejection of the CHC Counter-proposal |
| June | - | RHA approval of DHA proposal |
| November | - | Secretary of State's decision to re-open the Amersham GPMU. |

(Table 6-1 continued)

Second Proposal	Closure of the Delivery Services
1985 June	- Re-opening of the Amersham GPMU in part of its previous accommodation
	- Implementation of general management
	- Appointment of the new Chairman
1986 June	- Reappraisal of the plan to establish a RRU at AGH
	- Review of Amersham GPMU level of activity
September	- Informal Consultation on the proposal to close the delivery services vs postponing the RRU proposal.
November	- Formal consultation document Strong support for the RRU and CHC decision not to oppose the closure of the delivery services
1987 February	- Approval of the scheme to establish a RRU in the former maternity building re-providing post-natal beds in "G" ward
March	- Closure of the Delivery services
1988 January	- Shortage of staff: Opening of post-natal beds postponed.
February	- Decision not to staff the Unit in 1988 - 89. Need to re-open to be assessed in 1989-1990.

The previous section has presented an overview of the process and outcome of two successive proposals to close the GPMU at AGH since 1983. The next section details the genesis, the development, and the conclusion of each proposal to close the Amersham GPMU.

The First Proposal

By the time the first closure proposal was mooted, there was already a relatively long history of informal discussion concerning its desirability.

"As you will know it has been the policy of the RHA and before them of the RHB to have GPMUs as close as possible to the consultant specialist unit. This policy is also advocated by the DHSS and the RCOG. Quite understandably therefore there has always been some pressure on the DMT from the medical staff to carry out the transfer of all isolated maternity services to Wycombe"

ex-District Administrator

The pressure from the national policy has not been reason enough in the past to warrant the advance of such a proposal over and above other District concerns.

The DMT always refused to take any tangible action:

"You won't find it in the minutes anywhere but it was discussed many times. For instance when we were talking about cost saving proposals in 1979 which was a very difficult year. In the context of those cuts we thought about closing the Amersham GPMU. We did not go on with it for two reasons. Firstly we were aware of the political pressure. Secondly the closure would not produce the savings needed that year"

DMT member

The DMT was not alone in reaching the conclusion that the Unit should carry on regardless of the national policy. The last Buckinghamshire AHA also considered the closure of the Amersham GPMU but held fire on the proposal as well.

"A number of alternatives for centralising obstetric services have been considered on the grounds that GP Units should, wherever possible, be situated in closer proximity to specialist services. This will be difficult to achieve in this district, and, taking all considerations into account, the present arrangement of maintaining a GP Unit in Amersham should be continued".
(AHA Operational Plan 1983-84)

The take over of the responsibility for the closure of health facilities by the new DHA from the AHA and the radical change in the membership of the DMT brought about by the 1982 reorganisation set up a new organisational context for the closure to be reconsidered. However the most important factor which led the Authority to act towards closing the Amersham GPMU was the involvement on the DMT of one of the consultant obstetricians at WGH:

"I have to say that I was on the DMT. I was very anxious to have all the obstetric beds here. I have put that proposal up and the DHA took it on board. It was important I mean I felt strongly about it. The Amersham unit was not purpose-built for doing midwifery in that way and I was keen to get it (the centralisation) through. The argument was there before but we had not got the power to influence anything until then"

Consultant Obstetrician and DMT Member

The other members of the DMT saw the closure of the Amersham GPMU as an opportunity:

"The Consultant Obstetrician was the "flag carrier". However the DNO was the person who was pressing for it to happen quickly because it was putting pressure on his midwives and wasting money which was in his budget. The other members of the DMT could see some economic savings and were riding along the medical pressure"

DMT Member

At this early stage, the Chairman of the GP Committee who was a Member on the DMT took the view that his colleagues would reluctantly accept the proposal.

The Genesis of the Amersham GPMU Closure Proposal

The first opportunity to reconsider the function of the Amersham GPMU came up at the November 1982 District Review Meeting. It was agreed that the District should examine ways and means of rationalising its physical estate. As a result, a formal review was undertaken in February 1983 on a number of topics, including the obstetric services.

The concentration of all in-patient services at WGH emerged as one of the proposals put forward by the consultant obstetricians who reviewed the District maternity services. Nevertheless very little service planning was undertaken in the District before the Summer of 1983 since the key planning posts in the

management arrangement, namely the District Planning Officer and the Specialist in Community Medicine, were not filled until June. Then it was decided to produce an Operational Programme notwithstanding the absence of strategic plans.

"In view of the likely lack of growth in resources, the DMT considered it particularly important to produce a programme which would indicate the most urgently needed developments, and ways to release funds to finance them ... The Districts were encouraged to fund priority developments through generating savings elsewhere in their budget"

District Administrator

A draft of the DHA Operational Programme was issued on 27th September 1983. Comments on the proposals were invited by 30 November 1983. The conclusions of the service review were then brought out. The relevant paragraph on the Amersham GPMU reads:

"The review has shown a low level of occupancy, and more particularly a low number of deliveries. It is therefore proposed to concentrate all in-patient services at WGH. This will result in all GP maternity beds in the District being alongside the consultant unit"

Draft Operational Programme 1984-85

The DHA officers insisted in the first place on referring to the scheme, not as a closure and change of use but as a transfer of services, but this was wrong

since the DHA did not propose adding to the number of beds at Wycombe. In contrast to the closure, the transfer and the temporary closure of services do not require a formal round of consultation. There was already an important history of relatively successful transfers of services in the District without complying to the letter with the DHSS guidance and without formal consultation being carried out:

"The closure proposals were unusual in this District. I think they genuinely felt that it was a transfer not a closure. We started up in 1974 with the Stone Maternity Home being transferred. Then we had a terrible argument with the DHA over the so-called temporary closure of the Casualty services at Amersham and again a formal consultation paper was never ever put forward. Then they transferred the Shruberry Maternity Home to the Wycombe General Hospital and again the consultation did not take place"

ex-Secretary to the CHC

The addition of the proposals to the first Operational Programme produced by the DHA within the new NHS planning system was not meant to avoid the formal consultation on the closure.

"Any proposal to close or rationalise a service has to start somewhere. A good place to start is in the plan where all services are considered. That is why it started there. It may have been a mistaken view but it was one genuinely held ... There were new rules on consultation (introduced with the implementation of the NHS planning system) which were followed out to the letter"

District Medical Officer

The closure of the GPMU was initially considered concurrently with the transfer of the services for children at WGH.

"Again they were very reluctant to look upon the paediatric ward proposal as a closure. They wanted to call it a transfer of services."

ex-Secretary to the CHC

The relevant paragraph concerning the Amersham Paediatric ward read:

"Currently facilities at both Wycombe and Amersham are under-used with comparatively low occupancy. There is dispersal and duplication of specialist skills particularly medical and nursing. The Authority therefore wished to consider a proposal that in-patient facilities be concentrated at WGH ..."

Draft Operational Programme 1984-85

The District's reasoning for advancing the transfer of the maternity beds out of the AGH was threefold: (1) lack of safety, (2) lack of facilities, and (3) lack of use. In issuing the plans, the District Administrator, in conjunction with the District Treasurer, emphasised that the proposals were not made primarily to save money but to achieve a better use of resources and safer obstetric care. Although saving money was not presented as a primary concern for closure, the District Treasurer welcomed the opportunity to make a transfer between heads of

expenditure so that community nursing levels could be increased. At 1982 price levels, the net recurring revenue savings resulting from the closure of the GPMU was estimated to be in the order of £90,000. This was largely undisputed though the opponents did not understand how the saving would have been achieved. All nursing and support staff were to transfer to WGH to fill vacancies in the establishment.

The District Operational Programme contained both favourable as well as less favourable items and the DMT hoped that it would be agreed to as a whole.

"The Operational Programme was a package. Hopefully people would see the merit of the Operational Programme as a whole and they would accept the need to close the units. It did not work but that was the logic behind it"

District Nursing Officer

The Development of Amersham GPMU Case

As presumed by its Chairman and DMT member, the GP Advisory Committee, after consultation with the Medical Unit Management Team and the Maternity Liaison Committee, accepted on 29 November the rationale for closing the GPMU. However the Committee opposed the closure of the Paediatric ward.

The GP Advisory Committee decision was strongly contested by the GPs affected by the closure of the GPMU. The opposition was led by two GPs who felt

strongly about their right to care for suitable mothers in labour.

According to the GPs, the closure of the GPMU was ill-conceived due to ineffective consultation and the Advisory Committee's decision was illjudged because no GP directly concerned with the closure attended the Committee's meeting. Nevertheless, the Chairman of the GP Advisory Committee upheld the recommendation to the DMT. This led the District Administrator to assure the DHA meeting that the GPs were not actively objecting to the GPMU closure proposal.

The midwives affected by the closure were disunited. Therefore, both the proponents and the opponents were claiming their support. However the Wycombe District Nurses and Midwives Advisory Committee supported the proposals.

There was considerable press publicity on the proposal to close the services at Amersham. An opposition committee - CAWS - was set up by two Amersham residents. They were unknown in the local political circle.

"The public opposition was not led by the conventional radical revolutionary left but by two decent housewives who had their babies there and who were not officially associated with any political party. Their opponents could not find anything to wrong foot them politically. The conservatives did not see it as a labour party move against them"

Trade Unions representative

The public opposition campaign was supported by a broad range of individuals and local pressure groups.

"We did try to keep politics out of it. It was an issue that everybody could agree on and it came outside ordinary party politics. That's what gave us the extra push"

Secretary to the CAWS

The Trade Unions did not officially campaign against the closure.

"We thought that we would be able to stop the closure at Regional level because there were a number of members who are not normally sympathetic who were expressing a great deal of support in keeping it open. So it was felt that we didn't need to develop much more of a Trade Union campaign because it was considered that we had a majority on the RHA to sort it out. Funnily enough the fact that the Trade Unions were not as active may well have been what saved it more than anything else"

Trade Union representative

However some members of the staff affected by the closures as well as the Secretary to the JTUC joined CAWS.

The GPs while keeping closely in touch with the public opposition group were leading their own campaign against the closure.

The DHA Chairman dealt with many questions at a well attended public meeting held by the CHC on 7th November 1983. A petition containing 10,000 signatures protesting at the proposed closures was presented to

the DHA Chairman. The opposition startled the Chairman and the DMT Officers.

"We did not expect such opposition and a lot of the things we did made the opposition worse"

ex-Chairman DHA

On 16th November, considering the strength of the public outcry, the Authority decided not to proceed further with consideration of the proposal to transfer the Paediatric services to WGH but to undertake a comprehensive review of all aspects of the services for children in the District.

"We thought that if we fight on two fronts, closing both the maternity services and the children's ward, we did not have a chance to succeed. We decided to fight on one front. We went for the one which was the most obvious case which fitted in very precisely with the national strategy"

District Treasurer

Public opinion united primarily around saving the children's ward. However, withdrawing the proposal to close the paediatric ward did not appease the public opposition.

"At the beginning the children's ward was the main issue. When the children's ward had been given back we were then narrowly channelled on the maternity unit. We got caught up in the dirty work over the maternity unit. We did not think about not doing it because it was such a strong point of principle and CAWS by then had become quite a social group"

CAWS Secretary

All the original thesis for closing the Amersham GPMU was contained in a single paragraph of the DHA Operational Programme.

"The review has shown a low level of occupancy, and more particularly a low number of deliveries. It is therefore proposed to concentrate all in-patient services at WGH. This will result in all GP maternity beds in the District being alongside the consultant unit"

Draft Operational Programme 1984-1985

Throughout the period of consultation, various documents were issued by the Authority to substantiate their proposals and to answer the questions raised by the protagonists. These documents were inconsistent on the number of maternity beds in the District and erroneous on the staffing levels in midwifery. That fuelled the controversy and supplied the opponents to the closure with a further argument against the DHA case.

"Apart from the question of safety the prime reason that was put forward in those very early days was that they wanted to appoint more community psychiatric nurses with the savings. If the establishment figures were right as stated they were then we demonstrated that the Authority could do the transfer between heads of expenditure without closing Amersham Maternity Unit ... This made a good point when we met the Minister"

ex-Secretary to the CHC

Some of the DHA members expressed embarrassment at having to support publicly the proposed changes without the benefit of clinical information. The Chairman requested the members of the Department of Obstetrics and Gynaecology at WGH to submit a report concerning the possible "transfer" of the GPMU from Amersham to Wycombe. In effect, the report was written by the consultant obstetrician who was on the DMT and recommended that on grounds of safety, lack of facilities, and lack of use, the Amersham GPMU should be transferred to the Wycombe GP/Consultant Unit.

"It is an isolated 10 bed GP unit with no resident doctor available for emergencies ... We believe, therefore, from a safety point of view, that having a baby in an isolated GP unit is little better than having a baby at home" (Consultant Obstetricians Report, p. 7, emphasis is original)

The report was issued on 25th November. However, it was received by most protagonists almost a week after the closure of the consultation period over the Operational Programme.

A further difficulty was that the safety record of the Unit was much better than the consultant obstetricians' report indicated.

"The safety records of both the GP and the Consultant units in Wycombe were good. The professional views on the issue related partly to local knowledge and partly to a wider view of the role of isolated GPMUs ..."

RHA Planning Administrator

Therefore, closing the GPMU primarily on safety grounds proved difficult. The DMT emerged as not upholding a clearly focused cause:

"The original reason given for the decision to close the maternity unit was that the three consultants at WGH had decided it was unsafe. The allegation was quite untenable and having been shown to be wrong on safety, the Health Authority shifted its ground to savings, even though they had clearly stated at the outset that the search for savings was not the primary reason for their wishing to close the ward"

ex-Secretary to the CHC

The consultant obstetrician's report increased the furore of the GPs who used the facilities:

"The conclusions of the review of maternity services were not disclosed until the publication of the District Operational Programme. The GPs were upset because it looked like an attempt had been made not to alert them about what was going on. They got even more upset when the Obstetricians started turning on them as practicing unsafe obstetrics. It was not done sensitively at all"

ex-Chairman DHA

The DHA considered responses to the draft District Operational Programme on 14th December. The greatest volume of comments received on the District Operational Plan was indeed on the proposal to transfer the GPMU from Amersham to Wycombe. Many of these comments stressed the need to keep at least some post-natal beds at AGH.

After lengthy discussion, the Operational Programme was adopted. The Authority requested the DMT to investigate the possibility of keeping some post-natal beds at Amersham. An amendment that any discussion on the proposal to transfer the GPMU from Amersham to Wycombe be deferred for twelve months was lost by ten votes to nine. The Chairman exercised his casting vote against the amendment.

"I felt that delaying things further would become counter productive. I had always spoken in favour of closing the unit. I felt that I had to support the DMT. I got it wrong. That was a silly mistake on my part. I did not realise what effect it would have"

ex-Chairman DHA

The Chairman's casting vote caused a further impetus in the opposition movement.

"That was a little bit suspect in that a Chairman should use his casting vote to keep an issue going rather than closing the deliberation"

Secretary to the CAWS

Opponents to the closure were ready to do more than offer rational arguments for keeping the GPMU open. The Authority, at that time, was investigating the feasibility of developing a Rheumatology and Rehabilitation Unit (RRU) at the AGH. A rumour to this effect quickly spread. It was circulated particularly by some of the local Councillors.

"You are aware that my wife is a Rheumatology Consultant at Amersham. When I exercised the casting vote there was absolutely no thought in my mind that anybody would begin to think that I was trying to close the unit in order to favour the Rheumatology Unit. The publicity as result of it actually made things ten times worse"

ex-Chairman DHA

In fact, the RRU proposal was still some way off. There was no way of telling whether this proposal would take place. At this stage there was another area under consideration - namely the "G" ward - for the localisation of the RRU on the Amersham site and the financial support for such a unit was still uncertain. The RRU decision was pending and the DMT officers were hesitant about its feasibility.

"We were operating in a very uncertain financial climate. We could not put a precise date on when and where we were likely to achieve that. We had to be very careful we did not make promises that we could not fulfil"

District Treasurer/DGM

The Officers' indecision over the RRU proposal provided further reasons to suspect evil:

"There was probably an idea that the actual maternity building could be used as a RRU but it certainly did not come out ... If that was the original intention it should have come out but it was never put forward. The District Officers really avoided it"

ex-Secretary to the CHC

However, the rumour of the RRU struck the local press and the public imagination.

"The public saw it as very devious when the Chairman used his casting vote, given that his wife was the one who stood to gain out of it. I do not think there was any truth in the rumour. I have great respect for him but it was a very useful argument for us to bring to bear and it was very naive of them not to realise that it would have been used. It certainly swung the case without any doubt"

CAWS Secretary

The Secretary to the CHC inquired on 21st December about the intention of the Authority to issue a consultation document on the specific issue of closing the Amersham GPMU. On 6th January 1984, the District Administrator, on behalf of the Chairman and the DMT, indicated that the DHA had no intention of issuing such a document:

"Certainly the DMT did not want to do that at all. We felt that everything we had to say was in the existing documents and there was not much point in saying it all again"

ex-Chairman DHA

The decision shocked and strengthened the opposition. The procedures adopted by the DHA were fulfilling the requirements for the consultation on the District Operational Programme but were not complying with the consultation procedures on the closure of health facilities, particularly on the requirement that a period of informal consultation should precede the

formal consultation. Furthermore, the document did not meet the full requirements of a closure document particularly over alternative use of the maternity building.

"In terms of the bureaucracy we got it wrong there is no doubt about that. We were trying to get the overall strategy agreed but then we were picked off because we haven't followed the formal procedure in producing a consultation document on that one bit of the service. Where we got it wrong was setting out the proposal to close the service in our short term programme rather than signalling the intention of producing a consultation document"

District Treasurer/DGM

Underlying that the DHA failed to use the proper consultation procedure, the CHC resolved directly to oppose the closure on 9th January 1984.

The opponents stepped up their campaign. The CHC, the District Council, and the CAWS looked for legal advice, threatened to sue the Minister, held public meetings, wrote to DHA and RHA members, contacted the press and gained the support of a wide range of local and national associations such as the British Medical Association, Buckinghamshire Local Medical Committee, and the RCGP on the matter of principle involved.

Meanwhile the representatives of the GPs lobbied the members of the GP Committee who, previously, accepted the rationale for closing the GPMU and secured their back-up in the fight against the District

proposals. Eventually, the lobby led the GP Medical Advisory Committee to revise its previous recommendation and call on the DHA to open a "functionally integrated" GPMU at Amersham.

In the meantime, Sir Ian Gilmour - the MP for Amersham - carried out the lobby, particularly to the Secretary of State, the DHSS officers, and the RGM/Medical Officer.

Recognising that the District had not actually followed to the letter the proper consultative procedures and making no excuses for it, the DHA Chairman indicated to the RGM/ Medical Officer that the Authority did not wish to start the whole consultation process from Stage One. However, the Chairman consented to give full cooperation and sufficient time to the CHC and all the opponents to prepare a counter-proposal and to consider the implication of the closure.

The DHSS advice on the matter was confusing. On the one hand, the DHSS officers were of the opinion that the circulars were for guidance and not mandatory. Furthermore the closure of the GPMU was in line with the national policy and was openly welcomed by the DHSS officers.

"We were following a policy, a strategy that was not just local but part of a national strategy. Once the proposal had gone out of the local arena, the people who could be more

objective would see that we were doing the right thing. Some very senior DHSS officers were saying that it was a bit muddled because the procedure was not being followed precisely but that it was the right thing to do"

District Treasurer/DGM

On the other hand, the DHSS officers were estimating that the Secretary of State would be unlikely to give his approval if he was doubtful of the adequacy of the consultation procedures followed.

The line of action adopted by the DHA enabled the RHA Chairman to assure all the protagonists - and the local MP in particular - that the District was acting in the "spirit" of the procedure by allowing all sides time and opportunity to present their case. One of the DHSS officers, on behalf of the Secretary of State, issued a similar assurance to the Chiltern District Council. The Regional Officers were hoping that either a local agreement would be reached between the DHA and the CHC or the opportunity to present their case against the closure would assuage the opponents - and particularly the CHC and the GPs - in their criticism of the manner in which the DHA carried out the initial consultation. The first option would avoid the embarrassment of referring the matter to the Secretary of State, while the latter would increase the prospect of a favourable decision.

From January to March 1984, a number of meetings between the members and officers of the Authority and the GPs opposing the closure were held. In addition, the DHA Chairman held a series of special meetings with various interested parties to give a further opportunity for local discussion. In particular, a General Assembly between the Chairman, the DMT, the consultant obstetricians, the GPs who had access to the maternity unit, the Chairman and the Secretary to the CHC was convened by the Chairman of the DHA and held on the 28th February.

"After nearly two and a half hours there was some increased understanding of the problems but no changes in attitude or opinion. The argument for closure was then seen to be based not primarily on safety but on lack of use and cost"

GP representative

At the end of the consultation period over the closure of the Amersham GPMU, the GP representative pointed out that the attempts made to remedy the lack of consultation involved a great deal of work for the Authority. It demonstrated a united opposition of the Community and the GPs as it would have done at the end of a formal consultation. The Chairman of the CHC indicated to the Regional General Manager that sufficient time and cooperation had been available to prepare her counter-proposals.

"In reality, the publicity given in the local press to the proposed closure between October 1983 and March 1984 was such that no-one could have been unaware of the proposal. Even the strongest opponents of the closure agree that their views were amply made known to the Authority and to individual members before the decision was finally confirmed in March"

ex-Chairman DHA

Nevertheless, both the GPs and the CHC persisted in their complaints regarding the consultation procedures.

"The DHA has sought to correct the procedure by a series of meetings. These could not be effective, especially as they were held in the face of a decision to close the unit which, it was repeatedly stated, could not be changed"

Statement by GPs

The GPs reasoning was twofold: (1) the Amersham GPMU was not a totally isolated unit and had enough facilities to support life until the baby could be transferred and (2) the number of confinements from local Doctors could be increased considerably. To strengthen their arguments, fifteen GPs signed a petition addressed directly to the Secretary of State indicating their desire to continue managing the intrapartum care of their patients at Amersham.

The CHC issued its counter-proposal in February 1984. Setting aside the unconventional consultation procedure, the CHC reasoning was threefold: (1) the unit was not totally isolated from all specialist

resources since it was on the DGH site; (2) it had, for a number of years, an excellent safety record; and (3) it was not under-used.

"The DHA argued that the number of deliveries at Amersham was low and amounts to under-usage of the Unit. The number of births is only a partial indicator of usage. The CHC pointed to the high occupancy rate and short turnover interval which were among the best in the Region for GPMUs. Amersham GPMU was not under-used in the sense that it did not frequently have a large number of unoccupied beds, and it compared favourably with other such units in the Region"

RHA Assistant Planning Officer

Furthermore the CHC stressed that it was not realistic to expect the Amersham/Chesham GPs to travel so far out of their own area - 7 to 12 miles, 20 minutes to one hour depending on the traffic congestion - to practice obstetrics. However, the CHC accepted that the maternity building was under utilised and suggested, in conjunction with the GPs, that the GPMU could be accommodated elsewhere on the Amersham site. The old theatre suite vacated by the opening of the new operating theatres was suggested as a possible site.

"I walked round Amersham Hospital and in the end the only little corner that I could find that was not being used was the old operating theatres. So I got a Midwife to go with me and a GP you could just about manage to use the space. What in fact we were saying was: you maintain a maternity service we did not say that particular building"

ex-Secretary to the CHC

The District had difficulty in maintaining a momentum for implementation. The DMT considered the response from the CHC in March 1984.

"It was contemplated to call the closure off. We asked ourselves: would it make any substantial difference if we start again and follow the procedure? Our view was that we have done it in any case and the Chairman felt there was no need"

District Nursing Officer

An assessment carried out by the DMO concluded that a space twice the size of the old theatre suite was needed to accomodate the GPMU. The DMT members felt that the relocation of the unit on the Amersham site was not altering in any way the initial reasons for bringing forward its closure namely its relative lack of safety, lack of facilities, and lack of use. Therefore it was recommended to reject the CHC counter-proposals.

At the DHA meeting held on the 21st March, a proposal that the CHC counter-proposal be accepted was lost - 10 votes to 4 as well. The DHA referred the matter to the RHA as per normal consultation procedures.

The unconventional consultation procedure followed by the DHA and the opponents' decision to persist in their protests placed the RHA officers in a difficult position. Furthermore, following the DHA meeting, the

GP Advisory Committee was complaining extensively that the DHA did not specifically consider its resolution when the members decided to reject the CHC comments and counter-proposals.

In such circumstances, the advice given by the DHSS Regional Principal was that the closure proposal should not go to the RHA until the disagreement over the consultation process had been resolved. It was decided not to put the proposal to the RHA till the June meeting, allowing an extra month to get the paper ready and to make further attempts to assuage the GPs. The RHA officers and the RGM and Medical Officer in particular sought unsuccessfully for some sort of acknowledgement from the GPs as well as from the CHC that the appropriate procedure had now been followed.

In April, the draft District Strategic Plan was issued for consultation. It described a scheme to use the maternity building for RRU purposes.

In the meantime, an analysis prepared by one of the RHA assistant planning officers for the RTO did not show a clear-cut case either in favour or against the closure.

"On balance the substantive arguments for and against closure come down on the side of closure - but it is an uneasy balance. The Amersham Unit has undoubtedly been providing a safe, useful and valued service to local residents. Its existence is in line with current medical opinion on linking obstetrics with General Practice. The District as a

whole is slightly over-provided with maternity beds and the 10 beds at Amersham are the most obvious economies that need to be considered"

ORHA Internal Memorandum to RTO

Considering the uncertainty, it was suggested that the consultation issues were paramount and the RTO was recommended to oppose the closure of the GPMU. The Regional Planning Officer and the Planning Administrator were in broad agreement with the recommendation.

A month later, the matter was discussed at the Regional Team of Officers (RTO) meeting. The Regional General Manager and Medical Officer while agreeing with the analysis of the Planning Officers did not support their recommendation and she advised the RTO that, subject to further consultation to clarify the nursing and the medical advices, the case for closure should be supported.

"I felt that all parties have had sufficient time and information made available to them by the DHA, to consider the proposals fully. Notwithstanding the grumble on the consultation, the CHC made it clear verbally that all the substantive arguments against closure were adequately voiced. The Chairman of the CHC and the GPs representative were anxious that a decision should be taken swiftly and they advised me that there would be nothing to gain by extending the consultation period further. I was in touch with officers of the DHSS who were aware of the situation and were satisfied with the steps taken"

RGM/Medical Officer

The RGM/Medical Officer's additional consultation indicated that the number of transfers in labour from the Amersham GPMU to the WGH (13 cases out of 150 deliveries in 1983) was not excessive and that the GPMU could be supported on safety grounds. Nevertheless it did not provide a more clear cut case.

"We came down to the conclusion that we believed in the merit of the arguments any way. We could have made life extremely difficult for that process to be done successfully by making it starting all over again. We decided to take the issue as it stood. In these sort of circumstances we are less inclined to be heavy handed and more inclined to say that we are part of the body of the NHS and we have to weigh up the proposals"

RHA Planning Administrator

The Regional officers took the view that the case in favour and against the closure would remain unaltered by a further period of consultation. Therefore the RGM and Medical Officer recommended that the RHA should accept responsibility for considering the issue. Her analysis indicated that the strongest part of the DHA case was that the demand could be met by the beds at WGH. Another powerful argument was the net revenue saving at a time when the Districts were encouraged to fund priority developments through generating saving elsewhere in their budget. On the other hand the difficult traffic conditions made an

association with WGH impractical for GPs and therefore the closure would result in the loss of opportunity for the GP to practice obstetrics. She concluded that as far as the service was concerned it was a matter of preference between a valued GPMU and other unmet needs in the District.

"Management then has a choice as to how it uses its resources and the need to realise resources wherever possible to fulfil the many urgent tasks facing the District become dominant. In this climate the Amersham GPMU could be seen as something of a luxury"

RGM/Medical Officer

Both sides, proponents and opponents, intensified their lobby of the RHA members and officers and the main arguments for and against were restated. The GPs went further and proposed a unit of 6 to 10 beds staffed by community midwives.

"The GPs did not expect the Minister to turn the closure down. No doubt, part of their strategy was to try to make some sort of compromise. At that stage it would have been very difficult to compromise on the closure"

ex-Chairman DHA

The Chairman of the DHA as well as the Consultant Obstetricians emphasised particularly the development of services which were dependent, at least in part, on the availability of the building.

At its meeting on the 1st June 1984, the RHA agreed, by a vote of 9 to 4, in favour of supporting

the District plans to close the Amersham GPMU. The whole matter went to the Secretary of State, Mr Norman Fowler, for decision.

The Conclusion of the Amersham GPMU Closure Proposal

On 18th July 1984, as recommended by the RGM and Medical Officer at the RHA meeting, the Chairman of the DHA issued a public apology for not having followed the DHSS guidance in conducting consultation on the proposed closure. The fact that the Authority was allowed to reach such a position was pointed out as a matter of concern to the DHA members.

In September 1984 a new District Administrator was appointed.

"I really attribute most of the things that went wrong to our initial failure to get the procedure right ... I did not think it was really my place to examine what had been said from the point of view of compliance with the DHSS circular. That is the sort of things that the Administrator was supposed to do and he has always been good at doing that. He was held up as the Administrator who never made a mistake. Of all people who might get something wrong he was the last you would have expected"

ex-Chairman DHA

The Authorities were quite confident of getting a favourable decision from the Secretary of State. While awaiting the decision, the District detailed in its Operational Plan 1985-1986 the proposals for the re-use

of the maternity building for a RRU and the RHA allocated money towards the cost of converting the building. A Project Team was set up to discuss the conversion.

"In all the national trends that were taking place and considering that the temporary closure demonstrated clearly that we had the capacity to provide the service, we could not believe that it would take that long and that it would go against us"

District Treasurer/DGM

In contrast following their meeting with the Minister, the opponents were apprehensive about the decision.

"Just before the Minister made his decision we got involved with a public relations firm in High Wycombe because we thought they were winning at that point. The Minister was extremely well informed and that gave us some hope because we felt that the argument was so overwhelmingly weighted on our side. Nevertheless we were very apprehensive because we knew we were biased and he might be seeing it in a different light"

Secretary to the CAWS

The decision that the Amersham GPMU should be re-opened within a period of six months was officially announced by the Secretary of State, Mr John Patten, on 16th November 1984.

"Ministers saw the issues in this case as very finely balanced and were not satisfied that a case had been made which demonstrated clearly and convincingly that the closure of the Amersham GPMU and the concentration of maternity service in Wycombe would be a real

advantage to patients and to the community as a whole"

DHSS Regional Principal

The Second Proposal: A Comparison

The second proposal concerns the closure of the delivery service and the relocation of five post-natal beds in a redesigned ward on the AGH site.

The Genesis of the Proposal to Close the Delivery Services at AGH

The proposal to close the delivery services at AGH has its roots in the development and conclusion of the previous attempt to close the whole Amersham GPMU. The feasibility of providing only post-natal beds at AGH was mooted - as a practical compromise - in December 1983 as a result of the initial unfavourable public response to the Draft Operational Programme 1984-1985. However the idea was discarded in April 1984 on the basis of the RHA deliberation on the possible closure of the GPMU. It was rejected particularly on the grounds that it would occupy an important space already claimed by other priority services and that no capital development was available to rehouse the post-natal beds in facilities elsewhere in the Amersham premises.

In March 1985, in the context of the re-opening of the GPMU ordered by the Secretary of State, a committee of all interested parties agreed that a complete maternity unit should be re-established. Given the

time constraint imposed, the consultant obstetricians concluded that it was impractical to re-provide the facilities of the unit in any other location than the previous one, despite the fact that the maternity building was too large to allow an economical unit to be provided. The GP representative feared that this location would lead to continued problems regarding the viability of the maternity unit but he admitted that it would allow time for an appraisal of the possible relocation to a more appropriately sized building.

The Amersham GPMU re-opened on 3rd June 1985, with 8 beds and a delivery room in part of its previous accommodation. The re-opening of the GPMU was made without prejudice to the decision of its ultimate location or facilities to be provided in it. It was agreed with the RHA that the performance of the GPMU would be closely monitored.

The opportunity to reconsider the service provided by the Amersham GPMU came up from the June 1986 DHA meeting requesting the District Officers to undertake a reappraisal of the plan to establish a RRU at AGH. The decision ensued from the detailed planning by a Joint RHA/DHA Project Team of the proposals to use the whole maternity building for strategic developments, rehousing the GPMU in an existing building used as an on-site staff residential accommodation.

In 1984, when the DHA approved the Strategic Plan, it was thought that 26 R/R beds could be provided in the maternity building. However, the detailed plans worked out in 1985 had shown that it was possible to provide only 17 beds. The consequences in terms of revenue were important and the running costs of the RRU could not be reduced. Furthermore, the capital expenditure for the conversion of the staff residential building into a complete GPMU was fully a District responsibility. Altogether it was thought that it would not be possible to establish the RRU without detriment to other proposed strategic developments.

The closure of the delivery services emerged as a proposal put forward by the District General Manager (DGM) in conjunction with the District Medical Officer (DMO). The closure would reduce considerably the capital outlay of rehousing the GPMU. It would also save running costs which could be diverted towards strategic developments such as the RRU.

The closure was contemplated against a rather different background from that pertaining at the time the Authority undertook the prior consultation. The implementation of general management, the development of the Planning and Review System, the end of consensus management, the change in management structure from DMT to SMG, and the appointment of a new set of UGMs came

together to create a new context for the closure to be considered once again. It was also considered in a different climate of opinion. A massive - 27 million - redevelopment plan for the Amersham Hospital acute and priority services facilities was submitted in January 1986 by the RHA to the Chiltern District Council for approval. That soothed the local community fear for the future of their general hospital.

Yet, considerable blocking power existed. Because of the recent decision of the Secretary of State, action to close the delivery facilities was neither simple nor popular.

"None of the local people were in our favour at all. We knew as soon as the subject was raised again that we were up against everybody, including at the time the CHC. The RHA said: you are on your own if the CHC opposes the closure, it will go to the Secretary of State and it will get overturned again"

Unit General Manager

By the time the second proposal was mooted, two of the key figures from the first closure process had disappeared. Both the consultant obstetrician/DMT member and the DHA Chairman who championed the first closure proposal had been replaced.

"It was very clear that I would not be reappointed. As it happened I was in any case not able to continue. I suspected at the time that it might have something to do with the maternity unit but I subsequently found out that it did not"

ex-Chairman DHA

The appointment of a new DHA Chairman critically affected the balance of power for and against the closure of the GPMU and it contributed to setting up a more receptive context for reconsidering the future of the GPMU.

"It would have been difficult for me to close the delivery services. Having a new Chairman made a difference or, to put it negatively, not having me made a difference because the whole thing had been made personal the first time round"

ex-Chairman DHA

The leadership provided by the new Chairman of the Authority was another force for implementation.

"The Chairman already flagged it up that it was one of his high priorities. It had to be done one year or another and he decided that it would be done in his first year of office and he pressed on with it. That was a very brave decision considering that his predecessor had a pretty bad time as a result of the first closure proposal. He worked out a plan of action and made sure that the people involved knew exactly how and what we were doing and where we were going and he pulled us together as a team leader"

Unit General Manager

Understandably, there was a feeling within the SMG that the Amersham GPMU should not have re-opened at all. The original target of the second proposal was also to close the whole GPMU. The learning from the failure of the first proposal meant that the new Chairman was, however, more cautious in change

initiation. Considering the sensitivity of the issue, the uncertainty of going back out into public consultation only a year from the re-opening, and with the possibility of a National election, the initial target was readjusted.

"We changed it because it was easier to argue that we were closing only the part of the service which was not used than to attempt to close the whole unit again"

Unit General Manager

The compromise came from discussion between the Chairman and the DGM on what the public and the staff would be willing to accept on the one hand, and what would give the Authority the savings needed to pursue the implementation of the RRU on the other.

"What emerged when I talked to members of the CHC was their main concern was the lying in period and the inconveniences to family in visiting after the baby had been born. The GPs concerned wanted to keep the delivery services. Very clearly it was the CHC who had the power. We were able to say if you agree with the closure of the delivery services we would re-provide the lying in facilities elsewhere in the hospital. That was a very agreeable compromise"

District General Manager

The District reasoning for advancing the closure of the delivery facilities was essentially twofold: (1) savings, and (2) lack of use. In spite of a proportion of transfer in labour almost twice as high as when the first proposal was mooted, the safety of

the GPMU was not put forward as a primary argument for closure in order to avoid treading on the toes of the local GPs.

"One of the things that has caused anger among the GPs was the reference to safety. We reached an agreement that we would not use the argument of safety and imply that they were providing an unsafe service. The professional integrity was maintained"

District General Manager

However the primary reason stated for the closure was the development of the RRU.

"We really needed to develop a RRU. This was very important and we sold the RRU. That was what we went out to sell, not the closure of the maternity services"

DHA Chairman

The choice between the delivery services and the RRU provided a much more clearly focused cause than in the prior case and it contributed to split the opposition.

"By that stage the RRU was much more of a proposition. When we went back to the CHC we could then offer a choice. We were able to make it absolutely clear that all they were loosing was the delivery service"

District General Manager

The Development of the Closure of the Delivery Services

A discussion document, summarising the main issues, was produced by the DMO and sent to the CHC, the advisory bodies and staff representatives, seeking their comments.

"The technique we introduced was to talk to the people who could be difficult before issuing a formal consultation document. We drew their fire a little bit by doing that"

DHA Chairman

There is little doubt that the series of mistakes made by the Chairman and by the DMT members played a major part in the failure to implement the first proposal. The new Chairman was determined that, this time, no complaint would be expressed concerning the procedure adopted by the Authority in closing the facilities.

"The Chairman was very astute and careful about the public consultation and he made sure that the public were given as many facts as possible about the use of the maternity unit and as much information as possible about what development we did want to do and were not able to do because we did not have enough resources"

Unit General Manager

Having stressed the disappointing level of activity in the GPMU since its re-opening - an average of 2.5 deliveries per week, an over-all bed occupancy of 46% and a bed occupancy for delivery cases of 14% - the discussion paper concluded that unless there was a change in the policy concerning the provision of GPMU in-patient facilities, the Authority would have to consider delaying the investment into the RRU until the new building would be available in 1996.

A further discussion paper on the redevelopment of the AGH was sent by the DGM for consideration by the CHC Maternity and Child Health Working Group. The possibility of using "G" ward as a new location for maternity services, as well as the proposal to discontinue deliveries at Amersham, were put forward for informal sounding and discussion.

The outcome of the informal consultation were reported in the formal consultation document entitled "Development of Services at AGH - Proposed Change of Use of Buildings at AGH" issued and approved by the DHA in November 1986.

Given the recent decision of the Secretary of State to re-open the unit, the opponents of the closure were in a good position to resist it. However, even the strongest opponents, namely the NCT and the Joint Trade Union Committee, were cautious not to jeopardise the chance to develop a RRU at AGH. Most members of CAWS refrained from campaigning, deciding that they had already contributed enough to their cause.

"We did not feel we could go through it all again. There was nothing we could do about it without more time. You can not argue with declining figures in a way. People were not using the unit as they should have been. Most of the members of CAWS felt that although we felt very strongly on the issue we have done our bit and it was up to more recent users. The various people who were involved initially have moved on. The main GP representative indicated that he could not keep it going and that was someone else's

fight. Without him the others just haven't come forward."

Secretary to CAWS

Furthermore the proponents of the RRU proposal were not voiceless.

"CAWS held only one public meeting on the issue. There was not a huge support. There were patients there in wheelchairs who wanted to see the Authority having a RRU and said what they felt about the service provided for them and what could be provided as a result of the change of use. It actually deflated a lot of the arguments"

ex-Secretary to the CHC

Moreover, the Chairman and the District Officers used the local press and went along to a large number of public meetings to promote the DHA proposals.

"First time round we felt under attack. Then the second time round it was much more a case of saying we have got a defensible case and we will take it to you. We went to CHC meetings, NCT meetings etc. arguing the case out rather than releasing something by a press statement and the two sides never actually met as it were"

District General Manager

The GP Advisory Committee opposed the proposals on the grounds that it would result in a loss of opportunity for the GPs in the area to practice obstetrics. Notwithstanding, the GPs concerned while deploring the proposal were not obstructive in any way. That led the CHC reluctantly to decide not to oppose the proposal.

We always tried to be reasonable and when we looked at the usage figures we could not see that we could possibly justify opposing the change of use. We did not think that we would be justified in going through all that again if the GPs were not to support it. I had a long talk with the main GP representative who was bitterly disappointed about it all. In my view it was up to the GPs. If they would have opposed it and offered to support and to refer people there then fine, we would have opposed the closure but without the support of the GPs and in the face of the figures we let it go"

ex-Secretary to the CHC

A number of Districts and Town Councillors, while expressing regrets at the closure of the delivery facilities spoke publicly in favour of the change.

Opposition was primarily limited to the NCT and to the JTUC. The reasoning of the opponents was essentially twofold: (1) the GPMU did not have a fair trial since its re-opening, and (2) the improvement of facilities for R/R should not be at the expense of the maternity services at Amersham. The major complaint regarded the attempt to "manipulate" public opinion into a choice between the RRU and the maternity unit.

"They initially made a lot of noise in the local press but at the end it came to nothing"

ex-Secretary to the CHC

The Conclusion of the Closure of the Delivery Services

In February 1987, the DHA approved the proposals to establish a RRU in the former maternity building and to reprovide five post-natal beds in the "G" ward.

The beds were due to re-open in January 1988. In December 1987, following the visit of an Australian midwife who used to work in the district, fourteen midwives left to work in Australia creating a serious staffing problem. The re-opening was, therefore, postponed until recruitment for the posts could be completed. In February 1988, because of the financial situation and after having considered the political and possible implications of not re-opening the Unit, the SMG decided not to spend money to staff the Unit in 1988-1989.

"The circumstance conspired really to get us into the position we wanted to be and we have never re-opened the post-natal beds"

District General Manager

Concluding Discussion

This chapter amply described the progress of two successive proposals to close the GPMU at Amersham General Hospital by the Wycombe DHA. The first proposal failed dramatically whereas the second achieved a level of success un hoped-for. Why was the second proposal implemented so successfully when, only a few years before, the first one failed entirely?

The First Proposal

The first proposal to close the Amersham GPMU failed. Why was it so?

Lack of Political Sensitivity of the Leaders and Tactical Mistakes

The evidence suggests that the failure to implement the first proposal can be primarily attributed to the series of tactical mistakes made by the key people leading the implementation in handling the process and in presenting the proposal. Most notable of them were, perhaps, the Chairman's casting vote, the failure to enlist the cooperation and support from the medical staff directly concerned, the decision not to issue a specific consultation document on the closure of the GPMU, hence the lack of compliance with the statutory requirements for closure, and the publication of inaccurate statistics. These actions and decisions seriously undermined the credibility of the DHA Officers and the legitimacy of the proposal. In this case, the district leaders' lack of political sensitivity and adroitness helped in setting up a context which increased rather than diminished the motivation to resist implementation. The case study shows the type of difficulties that can occur in implementing closure proposals when there is little thought and action devoted to legitimising the proposal.

The failure of the district officers to recognise the political nature of the issue and the emotional appeal of the hospital in Amersham can, however, be associated with a number of contextual factors. The discontinuity at DMT level generated by the 1982 Reorganisation, and hence the loss of organisational memory, the pressure from national policy, the opinion of the Chairman supporting the closure and his autocratic leadership, and in particular the presence at senior level of an Obstetrician consultant acting as a "product champion" (Stocking, 1985), all played an important part in convincing the district officers that the closure of the GPMU was a logical and necessary change likely to succeed.

Lack of Awareness and Understanding of the Local Context

The philosophy and actions of the officers conform with the Rational Planning Perspective featuring implementation as a technical, non-political activity proceeding in response to directives arising from the top (see Chapter two). The evidence from the case-study suggests that an awareness and understanding of the local context is of major importance in implementing such proposals. In the review of the literature in chapter two attention was drawn to the failure of the classical approach to deal with the contextual forces.

The case-study indicates that the classical approach is inadequate for guiding the action in closing facilities.

The case-study also illustrates that the straightforward, top-down model of policy implementation does not describe accurately the dynamics of implementation of a closure proposal. The complexity of the rules and procedures of consultation, the absence of clear guidelines arising from the top, and the policy ambiguity were all reflected in the implementation process. The DHSS and RHA officers' ambivalence, as well as their abstention from interference with the DHA actions, featured also in the case-study. The evidence suggests that the centre's hold over the implementation of the policy was weaker than generally thought and that the periphery had more discretion than the conventional view of centre-periphery relations in the NHS assumes (Hunter, 1983).

The Will, Skills and Power of the Opposition

The failure to implement the proposal must also be attributed to the action of the opponents to the closure of the GPMU. As Behn (1978) pointed out:

"A public administrator may have the legal authority to close a facility, but others can raise the political costs of exercising that authority; and those whose sole concern is to keep the facility open can make those costs very high indeed" (p.335).

The opponents vigorously resisted the closure. They successfully discredited the Authority's Officers, undermined their ability to inspire confidence and trust, and delegitimised the proposal. The diffusion of rumours and the escalation of the problem were among the most notable "tactics of survival" (Behn, 1978) used by the opponents. They were able to build and capitalise on the lack of political sensitivity and tactical mistakes of the district officers and, ultimately, to convince the Secretary of State to reject the closure proposal and to order the re-opening of the GPMU.

A number of contextual features help to explain the success of the opponents in resisting implementation. The single DGH on split sites and the historical rivalry between Amersham and Wycombe, the shelving of the Amersham hospital redevelopment scheme, the past history of transfer of services towards Wycombe, the long tradition of maternity services in Amersham, the concurrent proposal to close the paediatric ward, are all important factors in understanding the negative public response to the closure proposals. These important inherited features were, however, overlooked by the DMT officers as a result of the loss of organisational memory following the reorganisation. Previous confrontations between

the two towns had left a network of people and groups readily available and competent to oppose effectively the closure proposals. This existing network was critical of the success of the leaders of the campaign against the closures in building up a powerful coalition to resist implementation. The culture of the community and, in particular, the widely shared belief that the future of the hospital was under threat also built up an "invisible barrier" (Lorsch, 1986) inhibiting implementation.

The Second Proposal

The DHA's second proposal reached a level of success which surpassed the most optimistic expectancy.

New People Providing Leadership

The second proposal was handled very differently to the first one and its success can be attributed to the skills and actions of the key individuals leading its implementation. Here it is important to note the decisive role played by the new Chairman of the authority. The contribution of the leadership could not have been more different. The core of that difference has been in the way the implementability of the proposal was assessed.

The departure of the District Administrator and the appointment of a new DHA Chairman can be

interpreted as supporting one of the central arguments of the Symbolic Implementation Perspective stating that organisational leaders can be used as scapegoats in implementation failures. Obviously, these changes at top management level contributed to re-establishing the confidence and trust in the management of the district necessary to the success of the second proposal. According to Stewart (1989), the ability to inspire trust is a particularly important requirement to managing in the NHS. As Hardy, 1985 indicated, it is a prerequisite to a successful closure of services.

"If management is deemed to act in good faith then its plans for closure are more likely to be accepted. If, on the other hand, potential opposition groups do not trust managers, they are unlikely to accept their decisions" (p.110)

One of the key contentions of the contingency approach is that change in structural forms and organisational processes are important factors in implementation. Clearly, the 1982 reorganisation assisted in the issue of GPMU closures being moved up the district change agenda. The radical change in the DMT membership generated by the reorganisation and, in particular, the involvement on the DMT of one of the consultant obstetricians at Wycombe General Hospital, played a critical part in the genesis of the first proposal.

It is difficult to establish precisely to what extent the post-Griffiths' structure contributed to the success of the second proposal. Clearly, the managerial style following the implementation of the Griffiths' report shows striking differences in comparison with the style which preceded it. The case-study indicates that the second closure proposal was undertaken with a much more positive and proactive approach than the first one. The speed with which the issue was put back onto the district change agenda can be interpreted as a sign of the impact of general management, since speedier decision-making was one of the main themes of the Report. The case-study points, however, to the influence not so much of the general management but of change of personalities and style at board level. The new Chairman and the DGM had complementary skills and formed a symbiotic team. They were able to frame a strongly based and well argued proposal for implementation which 'fitted' with the character of the locale and saved the relationship of the Authority with the clinicians.

A New Approach to Implementation: Organisational Learning

The case-study also presents an interesting example of "organisational learning process" (Argyris and Schon, 1978). Clearly, those involved in promoting

the closure of the delivery services had gained some useful experience in the management of closure and evolved a number of important changes in their approach to closure. The new approach had several distinct aspects. In particular, there was a clear political awareness of the issue and much emphasis placed on the formal closure procedures. From the outset, the proposal was conceived with the prerequisite approval of the CHC in mind and its officers were offered a genuine opportunity to exert real influence rather than a token consultation. The case study illustrates that not only the objectives of the closure proposal, but also the approach to initiate change, has to be legitimised.

The proposal itself, as opposed to the first one, was well sounded and strengthened by evidence provided by a negative evaluation of the service after a year of its re-opening. This demonstrates the importance of an analytic soundness in generating the data. Such an evaluation is one of the preliminary steps commonly recommended for closing a government facility (Ellis, 1983). This added to the credibility and legitimacy of the DHA proposal but, in addition, attention was also paid to the political requirements of implementation. Although the evidence from the evaluation could have been used to support the closure on safety grounds, no

reference was made to that issue so as to avoid treading on the toes of the local GPs. As Hardy (1985) pointed out, the justification of the closure on the basis of acceptable criteria is one of the key managerial strategies in reducing the possibility of resistance to closure. The GPs decision to support the second proposal was a key item in the SMG decision-making process to go ahead with the proposal. It also played a fundamental role in the decision of both the CHC and the public campaign group not to oppose the closure of the delivery services.

Combining Retrenchment and Development

Another key factor in the success of the second proposal was the combination of the closure of the delivery services with the development of an RRU at Amersham. Indeed, the provision of an RRU acted as a major incentive for the closure of the delivery services, drawing the CHC into participation in the process. The case study illustrates the role of incentives in putting together a coalition for change. It also shows that management can counteract the effect of contextual influences by acting adroitly and with sensitivity (Hardy, 1985, 1986; Hardy and Pettigrew, 1985). Not only was there a readily apparent performance gap to build in to justify the closure, but

the officers were able to put together a legitimate solution to meet an already legitimate problem. The case study also supports Korman and Glennerster's (1990) argument that public managers and bureaucracies can learn from their own mistakes.

A New Context for Closure and The Role of Chance

The significance of the learning process and the impact of the change in personalities and style at board level should, however, not be singled out from the critical change in the local context of the hospital. The success of the second proposal must also be attributed to the change in the attitude of the local community resulting from the approval of the Amersham hospital redevelopment plan. This major change significantly altered the culture of the locale; it eradicated the fear for the future of the hospital in the community and quietened down the opposition. Although the previous Secretary of State's decision was strengthening the position of the opponents, they were unable, in the new context, to legitimise their position and to build up a powerful coalition to fight and ultimately to win the issue. This clearly supports one of the key contentions of the CCSC research on change in the NHS stating that managerial and professional action as well as environment or policy

changes at higher tiers can encourage movement from non-receptive to receptive context for change (Pettigrew et al, 1990). The achievement of the total closure, when only the closure of the delivery was thought possible, nicely illustrates the role of chance, alongside foresight and intent, in implementation process.

Summary and Conclusions

To summarise, the evidence from the Amersham case-study shows particularly well that it is not enough to take obsolete central policy off the shelf; the action taken by the key decision makers as well as the personality, skill, and style of the leaders can be critical factors in implementation. The tendency of those who were trying to implement the first proposal to move quickly and with authority, and for action to dominate over legitimacy were clear features of the the first proposal. As Pettigrew et al (1990) pointed out,

"The issue may be one of balance, timing, and sequencing. But there are dangers in moving too quickly, skipping the selling of the new idea and the unselling of the old."

The second Chairman had the sense of strategy and tactics, the personal resources, and the political skill which were lacking in his predecessor.

"Political skill means the ability to use the bases of power effectively - to convince

those to whom one has access - to use one's resources, information, and technical skills to their fullest in bargaining, to exercise formal power with a sensitivity to the feelings of others, to know where to concentrate one's energies, to sense what is possible, to organise the necessary alliances. Related to political skill is a set of intrinsic leadership characteristics - charm, physical strength, attractiveness, what Kipnis calls "personal resources." (Mintzberg, 1983, p.26)

The analysis also demonstrates clearly that the implementation process was pervasively influenced by the context in which it was set. The case-study illustrates the effect of history and local characteristics on the reaction to the proposals. In particular it shows the effect of the history of competition between two major towns sharing the DGH services and the role of local politics in complicating the closure decisions. The evidence indicates that local context sensitivity was of primary importance in implementing the proposals. A further important point illustrated in the case-study is that contexts are changing and that relatively fast contextual changes can critically contribute to removing some of the major blocks on implementation.

**The Implementation of General Practitioner Maternity
Unit Closure Proposals in Hospitals**

by

Yvon Dufour

Dissertation submitted for the degree of Doctor of
Philosophy to the University of Warwick
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CHAPTER SEVEN

Abingdon GP Maternity Unit

The second case-study documents the progress of the Oxfordshire DHA's proposals to close the GP maternity beds in Abingdon. The first proposal put forward in April 1986 by the current District Executive Board formed part of a comprehensive set of savings intended to bring the District's income and expenditure into balance.

The whole set of proposals were vigorously opposed. The proposal to close the maternity beds at Abingdon was decried particularly by the local GPs. In June 1986, the Government's decision to defer part of the pay awards until July eased the District's financial situation. With the exception of the proposal on closing some of the Nuffield Orthopaedic beds, all the closure proposals contained in the package of savings were put into abeyance.

The proposal to close the Abingdon GPMU was re-launched two years later. The closure of the GPMU was the corner stone of a complex series of changes intended to consolidate the GP medical beds and to develop an EMI service at Abingdon Hospital. The GPs and the Midwifery staff reluctantly accepted the

Authority's proposal and the CHC supported the closure. The Unit closed on 31st December 1989.

The Profile of the District and Unit Under Study

Oxfordshire is the biggest district in the Region, both in geographical and in financial terms. It covers an area of over 237 000 hectares, which is the whole of Oxfordshire County, spends over 25% of the Oxford Region's budget, and is also a prominent teaching district.

In such a big District, the closure of relatively small peripheral GPMUs has not been seen by the senior Officers as a strategic priority.

"We have talked about the closure of the GPMUs for quite a long time. In fact it has been on the cards right since the inception of the District in 1974. However, it has always been seen as a relatively small problem. Do remember: Oxfordshire is the fifth in the order of size in the Country. This District is large enough to have first class senior officers. There is a lot of clinical development and a lot of stimuli. There is always something going on. Nothing is very slow streaming in this health Authority unless it is trivial. The GPMUs are the little bits of the service. It is such a tiny issue compared with some of the other ones that we are grappling with"

District Medical Officer

Oxfordshire has one of the lowest population densities in the Region and is essentially a rural county. There are concentrations of population in

Oxford, Banbury and Abingdon. All the other market towns are fairly small.

In 1984, the population of the district was over half a million. It was projected to increase by nearly 10% during the planning period 1984-1994. The age structure of the District's population was well below national average in numbers of elderly. However, one of the major problems facing the District was the substantial increase in the population of people over 75 years old. The problem was generally the same as commonly found throughout the Region: the need to substantially increase the provision for Geriatrics and Psychogeriatric patients.

The "centre of excellence" function of Oxford means that the District attracts an inflow of patients from each District in the Region as well as a sizeable inflow from populations beyond the Region's boundaries. The size of the inflow in obstetrics, the standards of maternity care, and the flexibility needed to meet future demands were among the disagreements between the District and the Region. The Region was concerned that the District was providing a higher level and quality of maternity services to its patients. To bring the District's maternity services into line with the Regional Plan would require a reduction of 49 in the number of maternity beds. The Regional Strategic Plan

suggested that the majority of surplus capacity was at the John Radcliffe Hospital. The conversion of these beds for gynaecology purposes by 1994 was considered.

The economic indicators of well-being reveals the District as rather prosperous and healthy. It has one of the lowest SMR in the Region. People living in the North of Oxford are highly educated and particularly influential in developing local health policies.

"Setting aside the University, which is the single most influential group, health policies in Oxfordshire are influenced by what is called the North Oxford Factor. This suggests that the academic families living in the North of Oxford form a very vocal community. We have wives of academics who can steer the public opinion quite well, quite easily, and quite effectively. The local maternity policies have been considerably influenced by this factor"

District Medical Officer

The District has thirty hospitals scattered over its territory. The hospital services are distributed through two fundamentally independent centres at Banbury and Oxford.

Oxford has a DGH spread over three major sites: the Radcliffe Infirmary (277 beds), the Churchill Hospital (371 beds), and the main teaching hospital, the John Radcliffe Hospital (620 beds). The District wishes to concentrate these facilities but does not have the necessary capital to do so.

"Because it is a teaching centre, Oxford has problems which are different from those experienced elsewhere in the Region, such as the need to associate closely certain disciplines, and the desirability of operating on a very few sites because of the complexities of organising teaching. A major problem in Oxford is the contrast between that and the multiplicity of sites on which care is delivered. It is very uneconomical and very difficult in practical terms to run a DGH acute service on three different sites in a town as congested as Oxford. The ultimate aspiration of the Authority is to close the Radcliffe Infirmary and to concentrate the services on two sites but the financial implication of a two-site strategy for Oxford is prohibitive"

Director of Planning & Performance

Oxfordshire also has another DGH in Banbury (252 beds). It is a more typical DGH without a significant teaching responsibility. The staffing ratios in Oxfordshire were below the Regional average in maternity services. Many beds were neither properly staffed nor available. The Horton DGH has 25 staffed consultant beds which is the minimum number for recognition by the RCOG of junior medical staff training. The hospital also has an integrated GPMU of 10 beds but only 5 of them are actually staffed. There is also an integrated GPMU of 12 beds at John Radcliffe Hospital.

One of Oxfordshire's distinguishing features is its large proportion of beds in peripheral units.

"There was a tendency in the NHS to centralise all DGH services. The old concept of the market town having its own facilities

was altered as the financial restrictions came to be more pressing. Whilst most districts have virtually closed all their town's hospital, Oxfordshire has not closed one as such. It was a philosophy and the local communities have given tremendous support to their local hospitals. Ironically, the costs in these units are much lower than in a DGH"

Unit General Manager

Setting aside the DGHs, acute in-patient beds are further provided in a dozen of fairly small peripheral community hospitals. In 1984, five of them were providing a total of 24 GP maternity beds (Table 7-0).

Table 7-0

**Complement of In-patient GP Maternity Beds
Oxfordshire DHA**

1974 - 1984

Hospital	GP beds		Births per available bed	
	1974	1984	1974	1984
John Radcliffe I	8	12	n/a	n/a
Horton General	10	10	n/a	n/a
Abingdon	12	3	11.6	5.9
Bicester	10	closed*	12.4	closed*
Brackley	4	4	41.2	20.76
Chipping Norton	12	10	14.2	7.4
Wallingford	16	4	13.9	21.6
Wantage	4	3	16.0	14.6
	-----	-----	-----	----- **
TOTAL	76	46	$\bar{x} = 18.2$	14.0

* Bicester GPMU closed in 1980

** Regional Average: 1974: $\bar{x} = 17.2$, 1984: $\bar{x} = 10.3$.

The decreasing number of peripheral GP maternity beds since 1974 resulted mainly from the rationalisation of services over the years.

"For historical reasons, there were GP maternity beds in the Cottage Hospitals but the demand declining their number was reduced. However, in spite of the national policy, it proved difficult to phase them out completely"

AHA Administrator

All the other hospitals in Oxfordshire are not providing acute and maternity services.

"To understand why we have not closed our peripheral GP maternity beds you have to understand something about the district's commitment to the development of local services. We are one of the districts which have pioneered the development of the community hospitals. In the early 1970s the Oxford Hospital Board and the DHSS initiated research on the role of the community hospital. We became a pilot district. The first real community hospital was built here in Wallingford. We illustrated how the traditional cottage hospital could be evolved and changed to be more intensive in their support to the local communities. The maternity unit was part and parcel of that."

Community Unit General Manager

The trend in obstetric workload indicated that whilst births, as well as in-patient cases, in DGHs increased, showing a general upward trend, the workload of the peripheral GPMUs was generally declining. The decrease at Abingdon and Wantage were particularly

striking. The bed occupancy in the peripheral units also dropped significantly.

Because most maternity units are staffed by Community Midwives, the closure of the peripheral GPMUs would result in only minimal revenue savings.

"Our peripheral GPMUs run a Domino scheme. They are not staffed by Hospital Midwives but by Community Midwives. Only Wallingford has its separated staff. Midwifery staffing levels are low. In South Oxfordshire, Abingdon and Wantage hospitals do not provide 24 hours midwifery cover. This is not recommended by the English National Board. The Nursing staff provide support care but the mothers are the responsibility of the midwife or the midwife on call. This system has been operating in Wantage for 25 years. It works at Wantage but it has not worked as successfully at Abingdon. We demonstrated that if you close the GPMUs you would need more, not less, community midwives spending more, not less, money. The GPMUs are a more cost effective option for providing maternity services than to run a community domiciliary midwifery service with all its overheads of staff on call. It is the more cost-efficient way of providing the next best to a home confinement"

Community Unit General Manager

The safety of the GPMUs has never provided a reason for closing the GPMUs.

"In the past fifteen years the only thing which has really forced the DMT or the Executive Board to take radical decisions has been financial difficulties. There was financially very little gain in closing a GPMU and it did not seem to be any gain in terms of healthier mothers and babies. There has been very little argument about safety locally. It just has not been a feature of the debate. The safety argument

is a carry over from the Pell report's day. In Oxfordshire it would be very hard to push that argument forward as the principal reason for closing a GPMU. It is a difficult argument to substantiate. We still run a flying squad. It is hardly worth it but we do"

District Medical Officer

The relatively good safety record of the District's GPMUs is attributed to the quality of local GPs.

"One of the reasons the closures were not pushed in the first place is the quality of our GPs. The consultants know the calibre of our GPs. We have good GPs and good primary health care teams. The District has committed GPs who have defended their wish to practice GP obstetrics. There is very little evidence of bad selection of patients. There is some evidence to support the hypothesis that the proximity of the "centre of excellence" is influencing the standard of our GPs. For instance, the analysis of the drugs bill of family doctors supports the assumption that it is influencing the speed in which new treatments are used"

District Medical Officer

The local strategy has been to keep the GPMUs open where they have GPs committed to maintain the service and to press the local GPs to consent to closing the maternity beds when the facilities could be better used for more urgent local needs. The District's philosophy has been that planning initiatives, involving a reduction of services, ought to come out from the unit level.

"Prior to the 1979 election, we used to receive a quarterly telephone call from the

DHSS asking for progress on the reduction in the number of GPMUs because of the national policy to phase these beds out. Oxfordshire was one of the AHA's regarded as very tardy in this respect by the Department. We were not prepared for economy or for safety to push ahead dramatically with the closure of the GPMUs. The overall policy, which started with the AHA and was carried on by the DHA, has been to wait until the GPs themselves and the public had made up their minds. It is much better if these decisions either originate with the GPs or are made to appear to originate with them. It does make the removal of the maternity beds considerably easier if they are seen to be fulfilling as great if not greater needs. As far as Oxfordshire was concerned we looked to discontinue the use of peripheral maternity beds as coming up either spontaneously or engineered from the local GPs. We seized any opportunity available whenever it presented itself and we tried to create opportunities by suggesting proposals, testing the feasibility of moving forward where there was a greater consensus, and setting up working parties"

Oxfordshire AHA Planning Officer

The closure of the Bicester GPMU is unanimously considered as a perfect example of the Oxfordshire's closure philosophy put into practice.

The Bicester Cottage Hospital had a total of 14 beds. In November 1976, since the bed utilisation for confinement was falling, eight beds were converted to medical and surgical use. The change was advocated by the local GPs themselves.

In June 1979, since the maternity bed occupancy was falling again, the GPs decided, by a majority vote, to cease confinements in Bicester from 30th December

1979, and to turn all the beds over to a mix of convalescent, post-operative, and geriatric patients. They issued a press statement giving details of the proposed change of use and explaining its motives.

The news took everyone by surprise. The AHA General Administrator set up a meeting between members of the Planning Team and the GPs to discuss the proposal and to assess the implications of the change. The CHC reacted immediately and put out a consultative document outlining the facts.

"In this case, the GPs acted quite arbitrarily in withdrawing their services from the maternity beds, without care for the other members of the staff. They made up their minds and put it in front of everybody as a "fait accompli". The press statement was a very disgraceful way of announcing such a proposal"

Secretary to the CHC

At the end of the consultation period, the CHC decided that it had no fundamental grounds for opposing the plans. The proposal was implemented on 31st January 1980.

The closure of the Brackley Hospital maternity beds is also a good example of the closure philosophy being put into practice. The Brackley Cottage Hospital had no more than 8 GP medical beds and 4 GP maternity beds. Closure in Brackley has always been a very sensitive political issue.

In October 1984, the impending retirement of the Senior Nurse raised doubts about the ability to maintain the maternity services. She was a very dedicated person who was covering up for the deficiencies in staff cover by working extra hours, largely on an unpaid basis.

At the request of the DMT, the UMG prepared an analysis of the options concerning the future of the Brackley Cottage Hospital. The four options were: (1) the continuation of all services, (2) the closure of the maternity unit as well as the casualty service, (3) the closure of all services, without additional clinical provision else where, and, finally, (4) the change of use of maternity beds to accommodate geriatric patients. The estimates of revenue consequences and the effect on clinical services, together with an assessment of the political acceptability of each option to the local community was considered.

The Chairman of both CHCs concerned, the Chairman of the Friends of Brackley Hospital, and the members of the Brackley Town Council were approached before issuing the consultation paper. In view of the likely opposition to the proposals, the factual accuracy of all quoted data was carefully checked.

The consultation paper presented all the options considered. The change of use of the GPMU was presented as a development of services.

"The change of use was not sold as a revenue saving but as a development of service. We insisted on the fact that in exchange for very lightly used obstetric beds, four much more needed general beds would be provided. You could take the public along with you only if you could tell them that they are going to get something out of it?"

Community Unit Manager

Despite the District's care in reducing opposition to the proposals, the closure of the GPMU was strongly decried by the GPs, the Town Council, and the public.

"Over the years there have been repeated alarms about the possible closure of Brackley Cottage Hospital and, understandably, a large body of opinion was already mobilised to oppose this. This issue and the GPMU proposals became linked in many peoples' minds. The main fear was that the Authority would close the hospital completely. Saying "yes" to the closure of the GPMU was saying "yes" to Phase I of the closure of the hospital"

Secretary to the CHC

Two well-attended public meetings were held. However, on 21st November 1984, the CHC finally supported the DHA's change of use proposal.

"This is the only occasion where our members went totally against the wishes of the public living in the area. There was overwhelming support for retaining the maternity unit. However, at the public meetings there were more people interested in maternity services than elderly people. Elderly people do not

go out to public meetings while young mothers do. A different audience would have produced a different swing of opinion. We received a number of letters supporting the change of use. That was the rational decision to make"

Secretary to the CHC

The Senior Nurse retired on the 31th March 1986 and the Maternity Unit closed the same day. The Unit was modified and since July 1986 now accomodates geriatric patients.

The District's maternity service strategy stressed its resoluteness to maintain both the integrated as well as the peripheral GPMUs. The overall strategy of development of acute and priority services pursued since the inception of the District in 1974 could be divided into three main periods:

- (1) 1974 to 1979, a period of development of General Acute Provision and Regional Specialities based on the opening of John Radcliffe Hospital Phase II. Closure of Cowley Road Geriatric Hospital. Re-use of beds in the Radcliffe Infirmary and Churchill Hospital for geriatric care. Development of the Community Hospitals;
- (2) 1980 to 1986, integration of acute geriatric and medical specialist services at John Radcliffe Hospital in Oxford and Horton General Hospital in Banbury. Closure of Bradwell Grove Hospital and joint development with the Local Authorities of a new mental handicap service based on a series of community units for severe mental handicap;
- (3) 1987 to 1990, improvement of elderly and EMI services. Minor developments to increase and improve the acute facilities.

The District change agenda has spared little place for the closure of the small peripheral GPMUs.

"In the last few years a great deal of our effort went into opening the new acute hospital and closing a geriatric hospital as well as a mentally handicapped hospital. Opening and closing health facilities is a highly time consuming business. These major changes took up our management time. Our efforts were diverted from the smaller things into the big challenges. The financial interest of closing the GPMUs was fairly small. The motivation was just not there"

District Medical Officer

The procedure for closure and the power of the local CHC also acted as deterrents.

"You must also remember the formal steps that you have to go through for closing health facilities. In Oxfordshire we have a big and rather powerful CHC. Until 1985 our working relationship with them was rather conflictual. We were always the faceless bureaucrats. In a place like Oxford it is easy to get the Authority bad publicity. The Secretary of the Council has always been able to convince people that the ordinary services were suffering because of the glory of the teaching hospitals. The Authority has shied away except for big things where the gains were considerable"

District Medical Officer

Because of the size of the DMT and the influence of the medical representatives, achieving consensus for the closure among the DMT members was also very difficult.

"In Oxford again we were different. Most DMTs had two medical representatives. We had

two consultants, one university professor, and two GPs. Getting a consensus on any closure of service was not an easy task"

District Medical Officer

The Management of the District

From 1974 to 1982 the District had experienced no change of senior Officers. The reorganisation brought a radical change in the DMT. Continuity was provided by the District Medical Officer alone.

The implementation of general management also brought notable changes in the management of the District.

"The difference between consensus management and the current arrangement is quite marked. Before the implementation of General Management we had a large consensus team. It got bogged down in details. A lot of talking took place and decisions were slow to come through. Implementation did not necessarily follow the decision. Members tended to get on very well together, it was a cosy management arrangement. The Chairman did not attend the meetings, the DMT ran the show. Today, every part of the service has a General Manager accountable to the District General Manager. We have a large management group and the Chairman frequently attends. It is always chaired by the Chief Executive. Leadership is a lot stronger. It has a much more executive style than it had before. The new Griffiths' management structure makes it more likely for decisions to be implemented. There is now a stronger will to implement changes"

District Medical Officer

Part of the new DGM's power has been decentralised down to the unit level management.

"There is much greater authority at this level. Providing that I have the money, I could get on with it. Obviously, this stems from the philosophy of the Chairman and the DGM. I am sure districts vary considerably on this. Certainly, the view of our Chairman and definitively the view of our DGM is that the UGM were appointed to get on with their money. What they do is their own business and if it goes wrong they will answer for it"

Unit General Manager

The effects of the implementation of general management in Oxfordshire have also been felt by the CHC.

"The Implementation of General Management has been a very good thing in Oxfordshire. When a conflict occurs we are now fighting at a more rational level than we would have been before. The Authority, even if it does not do what we ask it to do, is now responsive to what we want. It is a hard fought battle with respect and a great deal of friendship on either side. Perhaps we have been lucky in the two DGMs we had"

Secretary to the CHC

The first DGM was a consultant radiotherapist whose main strength was his ability to deal with the consultants in the medical school. The second DGM had been the Assistant DGM (Planning and Performance) and he took over the DGM job in July 1987. The District officers did not interpret the change as having dramatically altered the district style of management.

"The styles have to be different because one is a consultant and the other is a layman in medical terms. However, they worked very closely together and they made a very good duo. Both are direct, prefer informal communication, and above all are good

politicians in the medical sense and in the sense of the local community. They are both able to negotiate and certainly to compromise. However, the first DGH had more "charm" and, to some extent, was more able to deal with the senior consultants. Apart from his obvious managerial ability, the current DGM's strength derives from his local government background. He makes extensive use of committee to achieve his ends which is a good thing in a District like Oxfordshire. He has some good allies among the more powerful senior consultants in the medical school"

District Officer

Managing in Oxford is generally seen as different and more innovative than in the other Districts.

"What is different in Oxfordshire is that there is a lot of pressure. It is a very complex district. It is even more difficult in Oxford, there is no doubt about it. In terms of experimenting with new innovative ideas there is no other district with the comprehensive record that we have. The level of financial resource is low and imposes more pressure for innovative management."

Unit General Manager

For some respondents, the level of innovation has its down side.

"These people at the University are pushing back the frontiers of knowledge and in so doing they raise new ethical and priority questions all the time. The sad aspect is that it is more difficult to get management achievements. We have medical as well as quality of service achievement. However, our organisational priorities are diverged by the magnet effect of the teaching hospitals. We feel we lack a strategic framework in which innovation can take place. At the moment we do not have a very clear idea on the long term direction to follow as an organisation"

Director Planning and Performance

The Profile of the Unit Under Study

The Abingdon Hospital was built in 1901 and was originally an isolation hospital. When it was no longer necessary to provide facilities for those conditions, the hospital came under the responsibility of the Nuffield Orthopaedic Centre providing orthopaedic and physiotherapy services to the local population. From 1970s onwards, the hospital was being developed as a community hospital. In 1985, it had a total of 69 beds.

Up to 1968, local maternity services were provided by the GPMU at Warren Hospital in Abingdon. In 1968, because of work required at the building, the maternity services were transferred from the Warren to the Abingdon Hospital. This marked the opening of the Abingdon GPMU with 16 beds.

"We did not oppose the closure of the Warren maternity unit. The Warren Hospital was a geriatric hospital with a maternity unit. The closure was negotiated. We got quite good facilities at Abingdon Hospital as a result of the closure. We ended up with a Day Hospital, more beds for the elderly there, and the maternity unit as well. It was all agreed"

GP representative

In 1985, the Abingdon GPMU had only 3 beds. It was essentially used solely by one group practice of GPs. The maternity unit undertook 14 deliveries and, on average, 0.4 occupied beds (Table 7.1).

Table 7.1

**Abingdon GPMU Vital Statistics
Oxfordshire DHA, 1976-1986**

	1976	1978	1982	1984	1986
<u>% beds occupied</u>					
Obstetrics*	73	70	67	64	60
District GP Average	51	42	45	36	41
Abingdon GPMU**	53	31	40	30	13
<u>Discharges</u>					
Obstetrics	6343	6845	7238	7313	7412
District GP Total	2374	2032	1722	1747	1605
Abingdon GPMU	254	140	137	97	47
<u>Length of Stay</u>					
Obstetrics	8.0	6.7	5.8	5.4	4.8
District GP Average	5.0	4.4	4.4	3.5	3.6
Abingdon GPMU	5.0	3.4	3.2	3.0	3.1
<u>Birth</u>					
Obstetrics	5552	5942	6499	6640	6727
District GP Total	645	460	314	301	212
Abingdon GPMU	74	26	26	16	8

* Obstetric beds: 1976=183; 1978=180; 1982-1984=170; 1986=168

** Number of beds: 1976=6; 1978=4; 1982-1986=3

Source: Hospital Statistics 1976 - 1986, ORHA.

This concludes the profile of the district and unit under study. The next section presents an overview of the process and outcome of the two proposals to close the Abingdon GPMU.

The Closure of Abingdon GPMU: An Overview

From 1974 to 1985, the closure of the Abingdon GPMU was considered on various occasions. The GPs had always strongly opposed such a proposal and the closure was withdrawn time after time.

In April 1986, faced with continuing financial problems and the likelihood of overspending its revenue budget by half a million pounds, the Authority adopted a package of savings proposals, which included the closure of beds in geriatrics, obstetrics, orthopaedics, and in community care. It was also proposed to move the Pain Relief Unit (PRU) from Abingdon to Oxford and to close the ward at Abingdon Hospital. The PRU was sharing a ward with 8 GP medical beds. Since the GPMU was under-utilised, it was suggested to close it in order to accommodate some of the medical beds affected by the relocation of the PRU.

The closure of obstetric beds concerned 20 beds in the main teaching hospital. The Chairman of the Division of Obstetrics and Gynaecology indicated that he would not approve the closure of beds without ways of reducing the number of ante-natal admissions. He proposed opening an Out-patient Ante-natal Day Assessment Unit in the area vacated by the proposed bed closure.

The proposal to close the Maternity service and to transfer the PRU from Abingdon to Oxford were strongly opposed by both the GPs and the local community. The Clinical Medical Board of the University of Oxford did not comment either on the closure of beds at Abingdon Hospital or at the John Radcliffe Hospital. However, the Medical Board strongly opposed the closure of geriatric beds.

In June 1986, the Government's decision to defer part of the pay awards enabled the DHA to review the proposals.

"Cash limits meant that costs that rose more than the limits would have to be met from the ongoing allocation. The pay increases announced in May did exceed the cash limits although the extent to which they did was moderated by the device of deferring a part of the agreed increase until July 1. Nurses' pay was to rise by an average of 7.8% but because that award was deferred until July 1 (as opposed to the start of the financial year in April) the real value of the year's increase was 5.9%. Doctors and dentists were to get an average of 7.6% but, because of the deferment, effectively got 5.7%." (Small, 1989, p.75)

As a result, the DHA decided not to proceed immediately with the package of closures and particularly with the closure of the Abingdon GPMU. However, it was agreed with the CHC to continue reviewing maternity provision in the District. A pilot study was undertaken to test the feasibility of the Ante-Natal Day Care Unit proposal.

In 1988, an outside influence revived the project to close the Abingdon GPMU. The Imperial Cancer Research Fund built a new unit at the Churchill Hospital for cancer treatment services and offered to include facilities in the new building for the Abingdon PRU. That raised, once again, the issue of its relocation.

The closure of the GPMU was linked to a complex series of moves intended to develop an EMI service on the ward vacated by the PRU. A consultation paper was issued in October 1988. Virtually no objection was raised to the closure of the GPMU. The CHC did not hold a public meeting on the issue and decided to support the proposals. The Abingdon GPMU closed on 31st December 1989. Table 7-2 presents a diary of the main events leading to the conclusion of the closure process.

Table 7-2

Abingdon GPMU Case-Study
Diary of Principal Events

1985
April

- The Authority adopted a package of savings proposals which included the relocation of the PRU and the closure of the Abingdon GPMU;

Strong opposition from the local GPs and the local community;

July

- As a result of the Government's decision of part funding the pay awards the proposal to close the Abingdon GPMU was put into abeyance;

1988
October

- The proposals were re-launched. The closure of the GPMU was the corner stone of a complex series of changes intended to consolidate the GP medical beds and to develop an EMI service at Abingdon Hospital;

No objection was raised to the closure of the GPMU either by the GPs or by the local community;

1989
March

- The CHC supported the proposals;

December

- Closure of the Abingdon GPMU.

The Proposal

The previous section presented an overview of the process and outcome of the proposal to close the Abingdon GPMU. The next section details the genesis, the development, and the conclusion of the proposal.

The Genesis of the Abingdon GPMU Closure Proposal

The Abingdon GPMU opened its 16 beds in 1968. With demand declining, four beds were closed in 1972 and a further six beds closed in 1975 to accommodate some surgical post-operative patients. No objection was raised either by the staff or by the local community against these bed reductions.

In 1976-1977, a number of working parties were set up by the AHA to review maternity services throughout the area and to consider the future of the peripheral maternity units, particularly in Brackley, Chipping Norton, and in Abingdon. The dominant issue regarding the District's maternity services was the closure of obstetric beds and the addition of beds for gynaecology in the main teaching unit in Oxford.

The various working parties were not unanimous regarding the closure of the peripheral GPMUs. Generally, the working parties set up to consider the closure of peripheral units recommended that the GPMUs should remain on the basis that considerable value was

attached to their retention in the local hospital particularly by the GPs and the Nurses while the potential net savings were negligible. The other working parties, set up to consider the maternity services and closure of obstetric beds in central Oxford, supported the closure of the peripheral units particularly in Abingdon.

In 1978, the closure of a geriatric hospital and the need to accommodate the elderly patients into the existing beds led the Authority to reconsider the closure of the Abingdon GPMU. The first formal proposal to close it completely was then made. Following a consultation period, the proposal was withdrawn in response to strong pressure from the local community and GPs. A further two beds were then closed and the GPMU moved into a general medical ward.

"There was a large public outcry, strong support from the mothers in Abingdon, and from one GP practice in particular. The opposition was such that we finally agreed to move four maternity beds and a delivery suite from ward three to ward six. At the same time we stopped providing a complete 24 hour midwifery cover. That was a compromise which made the authority's peace, particularly with the GPs in Abingdon".

Community Service Unit General Manager

In 1981, the services provided by the Abingdon Maternity Unit were reviewed against the backcloth of the financial constraints and in the light of the

National policy of centralisation of the peripheral GPMUs. A new closure proposal was mooted. The proposal was abandoned in response to requests from the public and GPs to be allowed to demonstrate the viability of the maternity unit. A number of campaigners formed the Abingdon Maternity Support Group to continue safeguarding and promoting the local maternity unit. Births subsequently increased to a maximum of 27 in 1982 and declined annually after that.

"They justified the proposal by saying that it was the policy to close peripheral maternity units and to encourage the use of GPMUs attached to a consultant unit. We actually managed to show them that there was not any cost involved because it was staffed by community midwives. We pushed them hard on the statistics to prove that the hospital delivery was better than peripheral delivery and they were not able to present us with any."

GP representative

The proposal for closure was raised again in April 1986 by the District Executive Board (DEB). The District Treasurer was anticipating a deficit of over half a million pounds and the DEB recommended a set of saving proposals which included closure of beds in geriatrics, orthopaedics, and in obstetrics as well as the relocation of the Pain Relief Unit from Abingdon to Oxford.

"The second proposal to close the Abingdon GPMU stood, not from a review of maternity services but from the need for saving in

order to stay within the revenue budget. Once proposals have been raised, they do not tend to go away and they keep being raised in different contexts by the same people. We cast our minds around to find things that could contribute to savings, and the possibility of reducing maternity beds and closing the Abingdon GPMU came up again. It was only after the paper went out for consultation that we realised that the closure of Abingdon GPMU would hardly generate any saving at all"

Director of Planning and Performance

The proposal was primarily made in order to accommodate most of the 8 GP medical beds threatened with closure as a result of the relocation of the PRU in central Oxford.

The DHA used the opportunity offered by the statutory consultation over the package of savings to press its case for increasing its revenue allocation.

"The public consultation document and all the statements that were publicly made at that time were an attempt to keep the people fully informed of the situation and its cause. We felt that the difficulties we were facing were not the effect of bad management but the result of under-funding. One of the running sores in Oxfordshire was that when the phase II of the main teaching hospital opened in 1979, we did not get enough revenue to run it. The publications attempted to make that clear and to put political pressure upon the NHS Management Board and the Region to try to remedy to that situation"

Director of Planning and Performance

The package of savings was strongly opposed by the public, the medical and nursing staff, and the CHC.

"There was a general feeling in public opinion that it should have been the Cabinet and the RHA not the DHA which should have been in the dock. The problem was attributable to national priorities and funding policies. We were particularly concerned about the effects on the services caused by the method by which the RHA allocated revenue and capital to the eight DHA. A large reserve was held back by the RHA against the funding needed for Milton Keynes new development. We were certain that the District would not have been facing a serious financial problem if it had been given its proper share of the Region's resources."

Secretary to the CHC

The Clinical Medical Board of the University of Oxford did not comment on the closure of maternity beds either in the main teaching hospital or in the Abingdon Community Hospital. However, the closure of obstetric beds in Oxford was strongly opposed by the Chairman of the Division of Obstetrics and Gynaecology as well as by the consultant obstetricians in the main teaching unit on the basis that, given the referral patterns, it would result in a bed shortage during peak admission periods. An imaginative counter-proposal was developed by the opponents.

"The proposal to convert the space vacated by the closure of the obstetric beds into an Ante-natal Day care Unit came from the consultant obstetricians of the teaching unit. It was quite an innovative idea and a clinical development which aimed to reduce the number of ante-natal admissions without detriment to the clinical services and at no additional revenue cost. In turn, this

allowed a reduction of obstetric beds and a more efficient and effective use of the resources"

Director of Planning and Performance

The Medical Board of the University, as well as Oxfordshire County Council and Oxford City Council, expressed their strong opposition to the proposal of some geriatric beds in central Oxford.

The proposals to transfer the PRU from Abingdon to Oxford and to close the Abingdon GPMU were opposed by the Abingdon Maternity Support Group and the local community. The CHC opposed all the proposals included in the District's package of savings and suggested that the DHA should join the CHC in discussions with the RHA on the allocation of revenue and capital to Oxfordshire.

The DHA considered the responses at its meeting on 22nd July 1986. The financial position of the Authority was then eased by the Government decision on part funding the pay awards. The DHA decided not to proceed immediately with the set of proposals.

"We could have persisted with the whole package of proposals in which case, because of the opposition of the CHC, it would have gone to the Secretary of State for arbitration. The closure of the GPMU would probably have been accepted by the RHA but it was part and parcel of the whole package of savings. Seen against the total likely shortfall in the district's budget, the closure of the Abingdon maternity beds was really neither here nor there. The RHA officers were not prepared to support our

saving package as a whole. They indicated that they could not support us against the CHC. Besides, the members of the Executive Board and the District General Manager in particular were concerned about improving our relationship with the CHC. The last thing we wanted to do was to upset them. The local people and one GP practice, through the CHC, objected very strongly to the closure of the GPMU. The agreement was reached that we should carry out a further review of the maternity services which would include the Abingdon Unit".

Director of Planning and Performance

During the second half of 1986 and the first half of 1987, a series of meetings were held between the DHA and the RHA officers to revise the strategy for maternity services in the District. The District and the Region agreed to close a further 16 obstetric beds in the main teaching hospital and to set up an Ante-Natal Day Care Unit in the area made available by the closure. Further reductions in the number of GP maternity beds in peripheral units and the closure of Abingdon GPMU were considered possible, though not in the short term. Then an outside influence affected the momentum of the closure process.

The District was presented with an opportunity to reconsider the closure of the Abingdon GPMU in September 1988. The Imperial Cancer Research Fund was building a new unit in central Oxford for oncology services and offered to include facilities in the new

building for the PRU. The capital costs were being met entirely by the research fund.

The relocation of the PRU was threatening the future of eight GP medical beds. Because there was no funding to increase the number of GP medical beds to a viable level, it was considered either to close the remaining medical beds or to close the GPMU re-providing the medical beds in the space vacated. In any case, the whole ward freed by the relocation of the PRU would be made available to the Mental Health Unit for development of services for EMI. The latter proposal was championed by the Community UGM.

Setting aside the benefit of relocating the PRU in Oxford, the District's reasoning for advancing the closure of the GPMU was threefold: (1) lack of use, (2) needs in the Abingdon community for more not less GP medical beds, and (3) relative lack of safety of the very small maternity units. The proposals were introduced as a global development in terms of services to the local population.

"The closure of the GPMU was not presented as a revenue savings issue. We worked out the proposal as a trade-off between maternity services and services for elderly people in the local community. We kept an element of choice in our consultation paper whilst emphasising the reasons behind our own conclusion"

Community UGM

The Development and Conclusion of the Abingdon GPMU

There was virtually no opposition to the proposal to close the GPMU. The GP practice using the unit refrained from objecting to the proposal on the basis that local demand for delivery did not justify keeping the unit open.

"We opposed the 1978 and the 1982 proposals because we felt that there was then a sufficient number of mothers who wanted to have their babies locally. We preferred to have them in a small unit than at home and we believed that the number of home confinements would go up unacceptably if the unit was closed. In 1986, we opposed the closure simply because there was no alternative use for the beds. The District did not have the money to develop anything and a whole ward would have been left completely empty. We agreed that if the Authority could find the money to use the beds for some other purposes then we would accept the closure. Now, the number of local deliveries is so small that we could cope with them as home deliveries without difficulty. It would have been illogical to oppose the proposal"

GP representative

The midwifery staff also reluctantly accepted the closure proposal.

"The midwives were very sad. We would have liked to keep the unit open but unless it was supported by the local mothers, it was simply not viable. When the proposal was made in 1986, the booking for delivery stopped completely and it became very difficult to regenerate the work. For almost a whole year following the proposal, it was used solely by a handful of mothers for post-natal care. We now have occasional deliveries but we could not possibly justify keeping it open"

Midwife

No campaign group was set up in the local community to oppose the closure of the GPMU.

"When the threat of closure came again, the members of our initial opposition group were all heavily involved in doing other things. Such a campaign is very hard work. The GPs who helped us enormously in opposing the previous closure proposals seem to have reconciled with the fact that the unit could not keep going. They were not as interested in backing a campaign as they had been. The principal GP in charge of the unit at the time of the previous proposals was then seriously ill. Quite honestly, we were actually orchestrated a lot by the GPs and the midwives. Our group had a parish clerk who knew the local political scene very well and we got the support of all parish councils in the area. He also was heavily involved in doing other things when it blew up again. It was luck as much as anything else if the group initially came together to oppose the previous proposals. Basically, this time there was no leader or group to give the initial push to the opposition campaign. I certainly sat back and waited to see if somebody would step up and do what we did the previous times. Nobody did".

ex-Chairman of the Abingdon
Maternity Support Group

In December 1988, the Assistant Secretary to the CHC wrote to all individuals and groups who opposed the previous closure proposals informing them of the new Authority's proposals and requesting their comments about it. At the end of the formal consultation period, no comment was received by the CHC from any of the people consulted on the closure of the GPMU.

"There are all sorts of geographical and sociological reasons to why people do not appear to be fighting the closure of the GPMU

anymore. The whole area is changing dramatically. Abingdon is a market town with a rapidly expanding population. Much of the expansion is due to young families moving to the area. The outskirts of Abingdon are unrecognisable. Besides, the GPMU was primarily used by one well established GP practice. They were not taking many new patients. The "mothers-to-be" were sent to other practices who were not using the GPMU"

Assistant Secretary to the CHC

There were thirteen other papers out for consultation and because no objection was raised against the closure of the GPMU, the CHC decided to support the proposal without holding a public meeting on the issue. The DHA approved the closure proposal in March 1989. The Abingdon GPMU closed on 31st December 1989.

Concluding Discussion

This chapter has described the process and outcome of a series of proposals made by the Oxfordshire DHA to close some of its GPMUs and the Abingdon GPMU in particular. The closure of the Abingdon GPMU eventually went ahead successfully. The pertinent question to ask is why was the last proposal to close the Abingdon GPMU successfully implemented when, for more than ten years, all the proposals were either withdrawn or put into abeyance?

The Organisational Culture

Unlike the failure to implement the first closure proposal in Amersham, the unsuccessful outcome of the previous proposals to close the Abingdon GPMU cannot be imputed primarily to managerial mistakes. The case-study has provided sufficient evidence to show that the district officers truly believed in the virtue of the prerequisite clinical approval in implementing such a change. This is perhaps not surprising in a leading teaching district such as Oxfordshire where the power of the medical staff is prominent. Although a number of opportunities to close the Abingdon GPMU arose, the officers were reluctant to act towards the closure of the maternity unit without the sanction of the medical staff involved. It was only when the GPs' approval was ultimately secured that the closure proposal was finally implemented. The outcome of the various closure proposals, failure as well as success, can be primarily attributed to this important feature of the district organisational culture.

New Structural Forms and Organisational Processes

The prescriptive implementation literature emphasises the role of structure and organisational processes in bringing about change. There is no evidence that the 1982 reorganisation had had any

significant effect on the management of the issue in Oxfordshire. It is difficult to assess precisely what effect the change in structural form and organisational process resulting from the implementation of the Griffiths' Report had on the success of the final proposal. The proposal which arose a few months after the implementation of general management was put into abeyance. The process and outcome of that proposal can be clearly associated with the national political climate (see Chapter five) and with the controversy between the Conservative government and the Labour party about the funding of the NHS in particular. The District Executive Board (DEB) deliberate action, in using the consultation to press its case for increasing the district revenue allocation and to discredit expenditure cuts, can be interpreted from a Symbolic Decision Perspective of implementation (see Chapter two) as a "bleeding stump tactic" (Holmes, 1985).

"As in the case of rational public service strike, which aims to do maximum harm to the public in order to force government to yield, bureaucracies and politicians seeking to resist cuts may choose to concentrate those cuts in the places where they will most hurt the outside public, be most easily noticed, and thus court the maximum political unpopularity for the government. Such actors may actively help to orchestrate the chorus of protest against inhuman cuts ... This is the sore thumbs and bleeding stumps tactic" (p. 208)

However, the extensiveness and austerity of the whole DEB's package of savings, which included the closure of the Abingdon GPMU, can be seen as a sign of the impact of general management in the district. Considering the DMT structural complexity and the consensus management arrangement, it is unlikely that the DMT would have reached an agreement on such a controversial package of savings. The CHC handling and support for the final proposal can also be associated with the implementation of the Griffiths's Report, since improving the district relationship with the CHC has been one of the DGM's means of speeding up change in the district. Finally, the presence of a UGM championing the development of an EMI unit clearly contributed to the success of the last proposal. This can also be seen as an outcome of the implementation of general management.

Combining Retrenchment and Redevelopment

The content of the proposal also appears to have been influential on the outcome of the proposals. The final proposal concerned a redevelopment of resources for local priority services whereas the previous proposals were introduced as savings, resulting in a net closure of beds available in the district. This suggests that the economy rationale might not be

particularly effective for closing a government facility (Behn, 1978). The evidence also indicates that the overall problem definition can be important in persuading the various stakeholders and the GPs in particular to support the proposal or to choose spending some time and personal energy to challenge the closure.

Managerial Perception, Choice and Strategy

The question of closing the peripheral GPMUs and the closure of the remaining three GP maternity beds in Abingdon, in particular, was not regarded by the district officers as a desirable change per se. It was seen as a tiny issue compared to others. Furthermore, the officers thought that the local GPs' wish to keep their maternity units fitted with the nature of the district environment, as well as with its distinctive strategy of pioneering the development of the peripheral cottage and community hospitals. This indicates that managerial perception and choice can influence the pace of implementation of national policy. The data illustrates clearly that strategic priority made by the field agencies can substantially deflect the implementation of conflicting non-strategic national policy. As Hunter (1983) indicated:

"If the promotion of innovation is desired,
the power of the periphery to make policy

and, on occasion, to distort, delay or ditch national policy aims needs to be recognised" (p.144)

In any case, there was little managerial energy to spend on a possible controversy with the medical staff on the issue. Although a number of working parties recommended the closure of GPMUs, the District Officers were too busy implementing what they already had on board to take on further controversial change at that time. A number of contextual factors added up to the lack of pressure for change and contributed to keeping the issue off the active change agenda. These were: the size and complexity of the district, the soundness of the policy, the formal procedures for closure; the bottom-up philosophy of implementation and the extensive use of committees and working parties; the tradition of pioneering and innovation; the good performance of the units; the power of the CHC; and the sensitivity of the local community. As Ferlie and Pettigrew (1989) indicated the issues do not automatically give rise to agendas but require legitimation, need to be seen as feasible, and depend on a critical mass of powerful support. Clearly, these conditions were not entirely fulfilled at the time of the previous proposals.

The Implementation Approach

The philosophy of actions of the district officers conform to the Bureaucratic Process Perspective of implementation (see Chapter two) which suggests that hierarchical controls to alter the behaviour of relatively autonomous professionals generally fail and which recommends a bottom-up, as opposed to a top-down, process of implementation. In this case-study, the officers performed a supportive, enabling role as opposed to a controlling, managerial one in dealing with the issue. According to Hunter (1983), such managerial style would best fit with the pluralistic nature of the health care system and with the conditions for effective implementation in hospitals. The evidence from the case-study suggests that the Bureaucratic Process Perspective is a useful guide for implementation at micro-implementation level, as long as no strong contextual pressure or severe crisis conditions urge quick, decisive, and tightly integrated action. The package of proposals put forward in 1986 by the DEB illustrates that when powerful pressure exists, the managerial behaviour and style can change, at least temporarily. As Mintzberg (1983) pointed out:

"In such cases - we can call them state-of seige organisations - the CEO can get away with behaviours, such as squashing dissidents, that might be unacceptable in calmer times. There is nothing like trauma to

fuse all disparate influencers into one cohesive easily led body." (p. 365)

To a certain extent the action of the officers challenges the basic precept of the Strategy-Manager Perspective of implementation (see Chapter two) which suggests that managers lack the flexibility to adopt a range of managerial behaviour and styles.

Patience and Perseverance of the Promoters of Change

Although the district had not completely closed the Abingdon GPMU officers used the opportunities, as they presented themselves, to reduce the service levels according to the decreasing demand. These small interventions also helped in setting up the right conditions for the successful implementation of the proposal in 1989.

A number of features of context combined to prevent the district officers from acting against the will of the GPs involved. The evidence indicates that the pressure from national policy, the tightness of the local resources, and the district financial constraints in particular did not impose the closure of the district GPMUs. In the absence of sufficient pressure for closure, the proposal was difficult to legitimise and it tended to incur resistance particularly from the local GPs involved. The case study illustrates that in such circumstances signalling intention and opportunity

costs can be a useful tactic to test a possible closure without making full commitment to it because of uncertainty of the will of critical staff members.

Summary and Conclusions

In summary, the evidence suggests that there was neither sufficient pressure in the district nor a definite political will for the closure of the GPMUs. These features had a prime influence on the fate of the proposals. The organisational culture of the district, as well as the managerial perceptions and choices, were also important contributory factors in the process and outcome of the various proposals to close the GPMUs.

The implication that change may be seen as a long courtship between content, context, and process requiring repetition and opportunism, as well as commitment, patience, and perseverance of its promoters (Pettigrew, 1985), is clearly supported in this case-study.

CHAPTER EIGHT

Westbury Maternity Home and Bletchley GP Maternity Unit

The third case-study documents the closure of Westbury Maternity Home in Newport Pagnell by the Milton Keynes DHA. It also describes the progress of the proposal to change the use of the Bletchley GPMU. The two proposals were put forward in 1982 by the Milton Keynes DHA against the backdrop of the opening of the new DGH hospital. The CHC objected to both proposals. They were, however, approved by the Secretary of State and implemented in 1984.

The Profile of the District

Milton Keynes became a District in its own right in 1982. It is the newest and the smallest district in the Region covering an area of just over 31,000 hectares in the North of Buckinghamshire. It encompasses the designated area of the new town of Milton Keynes which incorporates a total of 13 small villages as well as a number of former traditional small towns such as Bletchley in the South, Wolverton and Stoney Stratford in the North.

"The growth of Milton Keynes as a new town took away Bletchley's identity but gave it lots of resources. By the time the closure of the GPMU was mooted in 1982, the town had already grown considerably; Bletchley was no longer a small community and did not have a

Parish Council anymore. That was an indication of the declining strength of the local community"

Chairman CHC

The market town of Newport Pagnell and other small villages in the north east of Milton Keynes are located outside the designated area of the new town but within the area of the health district.

"Newport Pagnell is a small town with an identity of its own outside the designated development corporation area. There is a quite articulate population in Newport Pagnell composed particularly of people who work for the Open University in Milton Keynes. There was a relatively long history of resisting the centralisation of public services. For instance the closure of the police station in favour of the opening of the station in the new town centre was strongly opposed by the people of Newport Pagnell. The closure of Westbury was seen as yet another case of Newport Pagnell missing out and Milton Keynes gaining"

District Administrator

The new town designed for 250,000 people is the largest entirely planned new urban development in British town planning history. The site was officially designated in 1967. Milton Keynes Development Corporation (MKDC) was then formed to plan and supervise the new town development and to coordinate the activity of the private sector and public authorities such as the Borough Council, the County Council, the Health Authorities and other statutory

agencies. MKDC has been a key lobbyist and a facilitator in social and health care policy (Ferlie & Pettigrew, 1988).

Milton Keynes has one of the highest population densities in the Oxford Region. Since the early 1970s the district has had the fastest population growth of any health district in the UK. In 1982, the population of the new town was over three times its initial population of 40,000. The increase, over the planning period 1984-1994, was estimated at over 40% against the national average of 2.5%.

Historically, the new town had developed through emigration from London in search of new council housing. Until 1983, the unemployment rate as well as the SMRs were above the national average. The population presented typical new town problems of high demand for health care. However, owner occupation and white collar employment has been expanding since the beginning of the 1980s. Meanwhile, the rate of unemployment has fallen dramatically and, since 1987, compares with the unemployment rate of the prosperous Southeast. Although the SMRs were high by regional standards in the early eighties, they have been falling and compare with the national average.

The population of the new town is much younger than the nation as a whole. The district has the

highest rate of childbirth in the country. Therefore both maternity services and paediatrics are strategic considerations.

Milton Keynes Community Hospital opened in 1979 on the future DGH site providing, for the first time, acute local hospital facilities. There were 17 GP medical beds in the Community Hospital. Phase I of the DGH opened in 1984.

"There was a long delay in providing the DGH. There was a lot of public pressure to have a DGH in Milton Keynes but the RHA was unable to get the capital from the DHSS to build it. In 1979 the Prime Minister, Mrs Thatcher, came to Milton Keynes to open the new shopping centre. Within a few weeks from her visit, the decision was taken that the project should proceed. There was a very rapid design period and the hospital started being built in 1981"

District Administrator

The new DGH made the district self-sufficient in maternity and paediatrics. The district is dependent upon Northampton and Aylesbury Vale Districts in all other acute and priority services.

Since 1967, the strategy of development of services pursued by the various authorities concerned has been dominated by the building up of new acute service facilities in the District. It can be divided into three periods:

- (1) 1967 to 1979, a period of dependency over neighbouring districts for all acute and priority services;

- (2) 1979 to 1984, opening of the MK Community Hospital and rapid development of acute services, based on the opening of the DGH Phase I;
- (3) 1985 to 1990, a period of development of acute services, based on the opening of the DGH Phase II, and development of elderly services through new facilities and development of community care.

The District has an ongoing extensive programme of major capital development. In particular, Milton Keynes is moving towards self-sufficiency in acute services by the opening of Phase II in 1990. The commissioning process of new facilities has been shown as complex, lengthy, and difficult for local management (McKee & Pettigrew, 1988). The success of the commissioning process of the Milton Keynes DGH Phase I has been questioned (Ferlie & Pettigrew, 1988).

"Different respondents used a variety of success indicators in their evaluation of the commissioning process. A number of the front line respondents however identified important flaws in the commissioning of Phase I relating to: inadequate resourcing and lead-in time, lack of clinical input; over-controlling regional tier (district view); over-controlling district tier (unit view); poor internal team dynamics; failure to plan for people and especially junior staff; a lack of clear brief or framework; the failure to de-brief properly. There were also fears that some of these mistakes would be repeated in Phase II" (p.63)

At the outset, a strategy for centralisation of all in-patient maternity beds on the DGH site was mooted by the Authorities responsible for the planning

of the new DGH. However, it was thought that centralisation could not be achieved until Phase III had been built in the 1990s.

Management of the District

Between 1974 and 1982, health services in Milton Keynes were run at district level by the Aylesbury Vales District Management Team (DMT). The formation of the Milton Keynes District as a separate identity in April 1982 brought a very radical change in its management. A distinct DMT was formed to run the new District.

None of the District Senior Officers appointed on the new DMT were from Aylesbury Vale DMT. Continuity was assumed by the District Community Physician alone. He had been a member of the new DGH Commissioning Team since its inception in December 1980. He became the first Milton Keynes District Medical Officer (DMO).

"The DMO had strong opinions about the closures and could not understand why some people were not seeing the logic and the benefits of the proposals. He was convinced that the AHA should have closed it in 1977. He championed the proposals. He adopted a rather provocative style which did not work well with the opponents to the proposals"

District Administrator

The GP representative was practicing in Bletchley for some years while the consultant representative, a consultant physician, was new to the district. The

District Administrator had been the Oxfordshire AHA Planning Officer and on the issue of closing the GPMUs he acted as the press officer and principal spokesman for the DMT.

"The District Administrator was a very prudent person who did not particularly enjoy standing on the front line and being put under the spotlight. Playing the game by the book was much more his style."

District Treasurer

The District Treasurer was particularly anxious to be seen as efficient. He grasped the opportunity of closing Bletchley GPMU to rationalise further the maternity services in the District.

"The idea of closing Bletchley initially started with the Commissioning Team. We were not too sure about it. We thought it would be politically difficult to achieve. The financial situation was reasonably satisfactory at that stage. Nevertheless the Treasurer pointed out that Westbury was very uneconomical and put forward the proposal to close Westbury as well as Bletchley redeploying the money for other purposes"

District Administrator

The first District Nursing Officer joined the DMT from a London District. She did not have particularly strong views about nursing and midwifery and saw the rationalisation as an opportunity to improve the midwifery services in the District.

"The Community Midwifery Service was not as large as we wished it to be and this was basically due to under-funding."

Rationalisation of the midwifery services on one site meant we were able to provide more community midwives undertaking more home deliveries and discharging, earlier into the community, those who do go into hospital"

District Nursing Officer

The chair of the DMT was rotated every six months among the DMT members. At the time the proposals were issued it was held by the District Administrator.

The new DMT members were all quite anxious to demonstrate their capability to manage the services.

"We were all newly appointed. Everybody was trying to establish his position in the hierarchy. To a certain extent, there was a fair degree of competition between the DMT members as well as a certain level of confusion about who was doing what. There was also a desire to go and show to our more established colleagues, particularly at Region, that we were there to do the job"

District Treasurer

The Chairman of the DHA was a local businessman and the deputy council leader in the Milton Keynes Borough Council. He controlled the direction of the District from behind the scenes and did not champion the District's proposals.

"At the two meetings held on the issue the Chairman of the DHA attended and brought with him all senior members of his management team. On both occasions he did not deal with the questions from the floor himself but let his officers and particularly the Medical Officer deal with them. Throughout the consultation he constantly avoided commenting on the issues assuring the public that the

question would be given the most careful consideration by the Authority."

CHC member

The formation of the new District resulted in the setting up of a new Community Health Council (CHC).

"Before 1982 there was a joint CHC which was based in Aylesbury with a fairly quiet branch in Milton Keynes. Most planning happened without much awareness of what was going on"

CHC Chairman

The new CHC, and particularly its Chairman, was equally anxious to establish its status.

"It was literally within weeks of the CHC being set up as a completely new body that the proposal to close Bletchley and Westbury was made. There was a new DHA determined to move forward in certain directions, enthusiastic about getting on with things quickly and keen to be seen as efficient. Equally, the brand new CHC was concerned to establish certain ways from which it wanted to work. A particularly important influence was the Chairman of the CHC. He has been on the right wing of the conservative group of the district council for quite a long time. The DHA officers were regarding us as a bunch of amateurs who represented nobody. At the personal level, our Chairman did not have strong views about the closure of the maternity units. However, he was very concerned to establish the CHC as a representative body which needed to be respected."

ex-Chairman of the CHC
Maternity and Child Care Group

The closure of Westbury Maternity Home and the change of use of Bletchley GPMU had been achieved for some time when the Griffiths' Report recommendations

were implemented throughout the NHS in 1985. As Ferlie & Pettigrew (1988) indicated, the management style which appeared to be developing in the District, particularly since the implementation of general management, displays the following features: (1) an emphasis on service innovation, (2) flexibility, multi-disciplinarity, and willingness to take risks, (3) political judgement, and (4) preference for informality in communication. The emergence of some of these features could be seen through the genesis, development, and conclusion of the closure proposals.

The Profile of the Unit Under Study

The Westbury Maternity Home was located in an old Victorian mansion house, built around 1870 by a locally well-known and rather influential chemist and farming family: the Tayler family. Its name had its origin in mediaeval times. It referred to its location on the West side of the burgh field, a common land belonging to the burgesses when the town was first established in the 11th century. It was dubbed the "bury" field by the local population. During the War the building was requisitioned by the Government. At the inception of the NHS in 1948, it started being used as a maternity home.

The physical condition of the building at Bletchley was very much better than at Newport Pagnell.

The Bletchley GPMU was purpose-built in 1962 by the Oxford Hospital Board as a means of increasing hospital confinements (see Chapter five). Other health facilities, particularly for the care of the elderly, were also built on the same site.

In 1981, Bletchley GPMU had 20 in-patient beds and two delivery rooms. The maternity unit undertook 492 deliveries. The GPMU also received 467 post-natal transfers, mainly from Barratt Maternity Home in Northampton. There were on average 10.6 occupied beds and 2.5 discharges per day. The average length of stay was 4.4 days. The Westbury Maternity Home had 16 beds and two delivery rooms. It undertook 220 deliveries and received 259 post-natal transfers. There were on average 5.7 occupied beds and 1.4 discharges per day. The average length of stay was 3.9 days (Table 8-0).

Table 8-0

GPMUs Vital Statistics
Milton Keynes DHA, 1978-1982

	1978	1979	1980	1981	1982
<hr/>					
<u>%beds occupied*</u>					
Bletchley	58	50	55	53	45
Westbury	35	38	35	32	36
 <u>Discharges</u>					
Bletchley	1035	875	874	873	724
Westbury	474	523	501	479	517
 <u>Length of Stay</u>					
Bletchley	4.1	4.1	4.3	4.4	4.5
Westbury	4.3	4.2	4.1	3.9	4.0
 <u>Births</u>					
Bletchley	492	434	420	406	325
Westbury	276	317	266	220	220

* Number of beds:
Bletchley GPMU: 20, Westbury Maternity Home: 16.

Source: ORHA, Hospital Statistics, 1978 1982.

Milton Keynes DGH had the opportunity to develop its services from a relatively low level of provision. There was concern for rationalising inherited estate almost only in services for the elderly.

The District had no tradition in obstetrics. Setting apart the GP maternity beds at Bletchley and Westbury, maternity services were provided in the form of consultant units in the Aylesbury Vale and Northampton Districts. Roughly one third of the consultants' deliveries were handled by Aylesbury consultants and two thirds by Northampton consultants. The opening of the Milton Keynes DGH in May 1984 triggered off the closure of Claydon Ward at the Royal Buckinghamshire Hospital in Aylesbury Vale as well as the closure of Windsor ward and Eleanor Hague Ward at the Barratt Maternity Home in Northampton District.

The Royal Buckinghamshire Hospital was a physically isolated maternity hospital comprising 44 consultant obstetrician's beds and 18 GP's beds which provided all maternity services for the Aylesbury Vale District. The ward had 11 consultant post-natal beds located in a temporary building. It opened in 1981 to relieve the pressure on beds due to the increasing population, particularly in the Milton Keynes District. The District had the lowest maternity nurse/birth ratio in the Region and welcomed the opportunity to improve

the staffing levels. The GPs, the consultant obstetricians, the midwives, and the Aylesbury Vale CHC raised no objection to the closure of the Claydon Ward and the proposal was implemented in December 1985.

Barratt Maternity Home had 102 GP's and consultant obstetrician's beds integrated to Northampton DGH. Windsor Ward had 6 beds and Eleanor Hague Ward had 16 beds. The closure of these wards was opposed by some members of the medical and nursing staff as well as by the CHC. It was argued that the projected increase in the District population necessitated keeping the facilities open. The Windsor Ward was permanently closed in January 1986 while the Eleanor Hague Ward was mothballed.

This concludes the profile of the district and unit under study. The next section presents an overview of the process and outcome of the proposal to close Westbury Maternity Home and to change the use of Bletchley GPMU.

The Closure of Westbury Maternity Home and the Change of Use of Bletchley GPMU: An Overview

The proposal to close the Westbury Maternity Home in Newport Pagnell was put forward by the new Milton Keynes DMT within a few weeks of its inception. It followed a recommendation made by a working party set up to consider the future of maternity services in the

District. The announcement of the proposal was made public in a consultation document issued in November 1982. The document also contained a proposal to change the use of Bletchley GPMU from obstetric to GP medical beds. The latter proposal was the prime "raison d'etre" for the review of maternity services in the District.

The change of use of Bletchley GPMU was the cornerstone of a solution developed by the District Commissioning Team to the complex problem of creating sensible shared facilities between the specialities that needed to be housed at the opening of Phase I of the new DGH in 1984. To achieve this aim it was proposed to combine the Bletchley GP maternity beds with the consultant obstetric beds in the new DGH. Then it was intended to bring to Bletchley the GP medical beds in Ward 1 of the Community Hospital on the DGH site. Finally, Ward 1 would be converted into a consultant managed medical ward.

The closure of Westbury Maternity Home was an adhoc proposal aimed essentially at releasing resources for more effective use. Taken altogether, these changes were centralising all in-patient maternity beds on the DGH site.

"The whole project began not as a way of unifying maternity services but of making more effective use of all the beds that were to be available. It was only afterwards that

we saw the benefit of centralising maternity services and its clinical advantages"

District Administrator

The proposal to change the use of Bletchley GPMU proved to be less controversial locally than the proposal to close the maternity home in Newport Pagnell. The nursing staff, as well as the medical staff, generally welcomed the proposal to combine the GPMU beds from Bletchley with the consultant obstetric beds in the Milton Keynes DGH. However, the GPs were concerned at the removal of GP medical beds from the DGH site to the Bletchley maternity unit. Ultimately, this was reluctantly agreed as a temporary measure.

An opposition committee, known as the Bletchley Action Group, was set up by some members of the local branch of the NCT. However, their campaign lacked impetus and the opposition group eventually merged with the Westbury Action Group.

The Westbury Action Group petitioned the DHA, organised a series of press events and lobbied the CHC to contest the closure. After a period of hesitation, the CHC, alongside the Action Groups and other local councils, finally decided to oppose both closures. The main effort of the opponents went into demonstrating that the Authority's birth rate projections were wrong and that the reduced number of beds provided for in the

DHA proposals would, therefore, be insufficient to meet the demand.

Neither the local MP nor the GPs strongly rose to the unit's defence. The JTUC, as well as the RCM, supported both proposals. The Milton Keynes Development Corporation made no formal observation on the proposals. Milton Keynes Borough Council opposed the closure but the Conservative majority on the Council abstained on the issue.

Despite the CHC's entreaty to extend the consultation period over the issues, the DHA approved the proposals in March 1983. The decision went to the RHA. In the electoral climate of Summer 1983 and on the backcloth of the renewed commitment of the Conservative party on the NHS (see Chapter five) the Regional Team of Officers (RTO) insisted on the District giving more time for consultation.

At the end of the extended period of consultation, the CHC restated its opposition to the proposals and the DHA reaffirmed its previous decision.

The RTO reviewed the main arguments and supported the request for permission to close both units. However, they required the DHA to proceed towards closure more slowly allowing for an overlap period of at least a year between the opening of the new DGH and the closure of the GPMUs. Although supporting the

closure of Bletchley GPMU, the Regional Medical Officer vetoed the key proposal to transfer the GP medical beds from the Community hospital to Bletchley.

The Secretary of State, Mr Kenneth Clarke, approved the closure proposals. He suggested an overlap period of 3 to 4 months between the opening of the DGH and the closure of the GPMUs to assess the new DGH services.

After having tried to find some way of modifying the acute bed allocation in order to retain the GP medical beds on the DGH site, and with the backcloth of the approval to close both units, the RMO finally agreed to the transfer of the GP medical beds from the Community Hospital to Bletchley.

The Milton Keynes DGH obstetric ward opened in May 1984. The Bletchley GPMU closed in June and the Community Hospital Ward 1 moved in. The Westbury Maternity Home closed in July 1984 and its building was demolished in June 1987.

Table 8-1 presents the diary of the main events in this case-study.

Table 8-1

Bletchley and Westbury GPMUs CaseStudy
Diary of Principal Events

1982	
August	DMT meeting to consider the Commissioning Team's proposal to swap beds between Bletchley and Milton Keynes. The DT stressed the need to consider the future of Westbury as well;
September	Working Party on the future of GP maternity services in Milton Keynes;
November	The Working Party's recommendation that both Bletchley and Westbury be transferred into the new DGH. Consultation paper on the proposals. WAG was launched. First public meeting;
1983	
January	Second public meeting. CHC Maternity and Child Care Group recommendation to close Westbury keeping Bletchley open. CHC decision to oppose both closures.
March	The CHC asked for a further period to make additional comments. The DHA adopted the proposals. The RHA asked the DHA to extend the consultation period;
April	CHC Special General Meeting restating its opposition to the proposals.
May	The DHA reaffirmed its previous decision;

Table 8-1 (Continuation)

June	RTO recommended supporting the DHA's decision to close Bletchley and Westbury but rejected the proposal to swap beds between Bletchley and Milton Keynes. The RT recommended to keep both units running in parallel with the new DGH obstetric ward for at least a year;
July	The RHA approved the RTO's recommendation;
1984 January	The Secretary of State approved the closure of both Units;
February	The RTO withdrew its objection to the transfer of GP beds to Bletchley;
8th May	Opening of Milton Keynes DGH obstetric ward;
11th June	Closure of Bletchley GPMU;
1st July	Closure of Westbury Maternity Home;
1987 June	Demolition of the Westbury Maternity Home building;

The Proposal

The previous section presented an overview of the process and outcome of the proposal to change the use of Bletchley GPMU and to close Westbury Maternity Home. The next section details the genesis, the development, and the conclusion of these proposals.

The Genesis of the Closure of Westbury Maternity Home and of Bletchley GPMU

Until 1977 the services provided by the Westbury Maternity Home were managed by Northampton Health District, which was part of the former Northamptonshire AHA. The responsibility for managing the maternity home was then transferred to Aylesbury Vale District, which was part of Buckinghamshire AHA. The GPMU in Bletchley was also managed by Aylesbury Vale District.

For many years, Westbury Maternity Home has had the lowest average occupancy levels in the Oxford Region. In contrast, Bletchley GPMU has had one of the best occupancy levels in the Region since its opening in the late 1960s. Setting apart the current proposal to change its use, Bletchley GPMU has never been formally considered for closure. A proposal was mooted in 1978 but it never reached the staff ears.

A proposal to close the Westbury Maternity Home was put forward by the Buckinghamshire AHA within weeks of its take-over from Northamptonshire. The proposal was strongly opposed by the local community and did not have the support of the Milton Keynes Development Corporation. The opponents argued that the increase in population would justify keeping the maternity home open in order to cope with the demand. Since the DGH was still some way off, and considering the difficulties in accurately forecasting the population

changes, the AHA finally withdrew its proposal. The maternity home was then kept open entirely.

At the time of the Regional Strategic Plan review in 1980, a strategy for centralisation of obstetric beds on the DGH site was mooted but no firm decision on the future of both units was taken. It followed a feasibility study on the closing of both GPMUs in view of the opening of the DGH. The principle of an integrated service at the DGH was agreed. The sketchy outline presented at the regional review suggested that provision for additional accommodation could be incorporated into Phase II so that a GMPU could then be centrally located with the consultant obstetric unit on the DGH site. Provisional thoughts envisaged a unit for the mentally handicapped at Westbury and a unit for the younger disabled at Bletchley. No objection to the principle was raised by the RHA.

The opportunity to reconsider the future of the district GPMUs came from two different directions: (1) up-grading work required at Westbury Maternity Home and (2) the problem over siting of beds in the new DGH.

In April 1982, when the Milton Keynes DHA took over responsibility from Aylesbury Vale Health Authority, the Regional Work Officer indicated to the new DHA that capital work needed to be undertaken at Westbury Maternity Home. For safety reasons, this work

was considered to be a high priority. The Acting District Work Officer took the view that the disruption to patient care, resulting from the work, would be considerable and therefore plans were necessary to close the Home for that work to be carried out. The total cost of the work to bring the fabric and condition of the existing buildings up to an acceptable standard would be in the region of £60,000. It would be financed from the Regional Estates Funds, provided that the maternity home remained open to provide health care services for at least another ten years.

The new DHA questioned the low occupancy of the maternity home and stressed the need to develop a maternity policy on the opening of the DGH. The DMT considered the maternity home as a capital resource and recommended that the required works should proceed. However, because of other priorities in the change agenda no further action was undertaken immediately.

Six months later, the DMT examined a solution developed by the District Commissioning Team to the problem of creating sensible shared facilities between specialities and sexes which needed to be accommodated in wards which would be available at the DGH. The problem arose as a result of trying to accommodate an additional speciality into Phase I of the DGH.

"In the original planning of the hospital it was not considered necessary to open an ENT

department in its Phase I. It was also assumed that 16 out of the 69 maternity beds provided in Phase I could be temporarily used for gynaecological patients. Discussion with various bodies suggested that we needed to have an ENT department. It was also discovered that because of the nature of maternity care, neither Gynaecology or any other speciality for this matter could share facilities with obstetrics. The closures of the GPMUs arose as a result of trying to accommodate yet another speciality while relocating Gynaecology in what was already an overstretched facility. This was a local problem which had nothing to do with any sort of government directive or regional strategy to centralise the peripheral GPMUs"

DMT member

After grappling with the problem for some time, the DMT concluded that the only solution was to transfer the GPMU into the new accommodation in the DGH and to transfer into the accommodation vacated at Bletchley the existing GP medical beds already on the DGH site. The latter beds would thus be vacated and ready to take one of the eight specialities which needed to be fitted into the new hospital accommodation.

The District Treasurer drew the DMT's attention to the need also to reconsider the question of the future of Westbury Maternity Home. Because of the capital works which needed to be undertaken, the high running cost of the maternity services and the low level of occupancy of the maternity home, the District Treasurer

suggested transferring the GP maternity beds initially from Westbury to Bletchley and eventually into the DGH.

In any case, a Working Party on the future of GP maternity services was set up in September 1982 to consider the proposals in greater detail. In addition to the appointed DHA members, party meetings were attended by DMT members only. No members of the medical staff concerned by the changes were directly involved in the discussion.

"The DMO ran the closures by himself. He did not take professional views from the consultant obstetricians simply because they were not appointed yet. At that stage the DMT felt that there was no need to involve the GPs in the process since there was still no proposal to submit to their attention"

District Administrator

It soon became apparent to the Working Party's members that the District Treasurer's proposal would be untenable and politically difficult to implement before the opening of the DGH.

"The transfer of Westbury to Bletchley has never been considered as a viable proposal and was definitively discarded after the first meeting of the working party. Not only would that have stretched Bletchley to the limit but we did not have a chance to succeed in selling that to the people living in the northern extremity of the District. However, it turned out to be the forerunner of the proposal to centralise all the GPMUs at the opening of the DGH"

District Treasurer

Further thought led the DMT to support the centralisation of all in-patient beds on the DGH site. The idea of centralising all GP maternity beds had been around long before the problems facing the Authority in opening the new DGH, but the problems arising from commissioning the new buildings were giving a new legitimacy to the closure proposal.

"Once we introduced the idea of centralising all the maternity beds in the DGH we got enthusiastic about it. We were convinced that it was the right thing to do. All maternity beds in the new DGH were to be used for their original purpose. It meant that there was not any shared facility at all. That was enabling the maternity beds to be approved for training purposes. GPs were having immediate access to specialist facilities. Post-natal transfers were eliminated. Savings were made. The centralisation was a wholly encompassing solution to a series of problems facing the Authority"

District Administrator

The emphasis in submitting the proposals for consultation was placed on the most efficient use of resources rather than the need for economy.

"Although we always insisted that the closure of Westbury was not a financial question it was in fact driven by financial consideration more than anything else. We tried to argue on the ground of clinical practice rather than cost. We were very careful to say that the whole proposal was not about saving money because we felt that this would be a counterproductive argument"

District Administrator

The district's reasoning for advancing those changes was twofold: (1) early achievement of the District's long term intention to centralise all inpatient maternity beds and (2) effective use of resources.

The consultative document insisted that it was the District's intention eventually to bring together all in-patient maternity services on the DGH site.

"The policy was already published in the Regional Strategic Plan and other Districts had already closed their isolated GPMUs. It was not a perverse Milton Keynes' idea. We were the baby in the whole region and setting standards was important. We could not afford to lie behind the other districts. We were merely achieving the inevitable changes sooner than expected"

District Administrator

It was also stressed that centralising maternity services was making a more efficient use of midwifery staff. The savings resulting from the closure of Westbury was enabling expansion in the level of community midwifery care.

The Development of the Closure of Westbury Maternity Home and of Bletchley GPMU

The proposal to change the use of Bletchley GPMU did not meet opposition from the GPs or from the staff involved. However, some GPs were concerned about the level of facilities available in Bletchley to back up a Community Hospital.

"Most GPs were quite interested to have the community hospital here in Bletchley. To be honest, there was some apprehension concerning the availability of supporting staff, Physio, O.T's, as well as regarding the access to the diagnostic services. Although it was generally accepted that for 100% safety the GP unit should be at the DGH, a handful of local GPs felt that with immediate help only a few miles away the unit should not be closed. However, the closure of the GPMU was combined with an increase of three GP medical beds. This was most welcomed"

Bletchley GP

The midwives supported the proposals but pressed the Authority's officers to increase the number of GP maternity beds provided in the new DGH.

"Several midwives wanted to go to the new DGH and supported the proposal to close the GPMU in Bletchley. There were many emergencies which we faced which could have been better dealt with if immediate consultant aid would have been at hand. However, we contested the length of stay of 4.5 days used by the DHA officers to work out the capacity of maternity beds. We thought it was unrealistically short considering the social conditions in the District and the number of beds provided would not be adequate"

Bletchley Sister

The midwives' view on the number of GP beds was supported by one ex-member of the District Working Party set up to consider the future of GPMUs.

"The planners took 16 because it was the number of beds which was available in the new building. There were 69 beds in the new wards and 53 were already allocated to obstetrics. The Commissioning Team took the view that no change could be made to the

number of obstetric beds particularly because of the requirements of the RCOG for proper training facilities. This left 16 beds for some other speciality. There was no thinking out from scratch to find out the number of GP beds which were actually needed"

Bletchley GP

The Newport Pagnell GPs and the midwives did not rise to the defence of the Maternity Home.

"A considerable number of Newport Pagnell GPs felt that the Westbury Maternity Home offered them no more facilities than attending a home birth. There were very few back-up facilities and they were getting worried about taking on caring in those cases. The building was substandard. They were also being offered a brand new GP unit down at the DGH"

Newport Pagnell GP

However, one GP practice joined the public campaign against the Authority's proposal. They were dependent on the maternity home for their patients ante-natal care. They argued that the closure would stretch considerably their Health Centre while there was no money to extend it. They also pointed out that the new GP beds would be too far away for them to continue practicing obstetrics, limiting the choice for Newport Pagnell mothers.

Two Action Groups were set up by local members of the NCT, one for each unit. The Bletchley Action Group met some difficulties in enlarging its membership base

and eventually merged with the Westbury Action Group (WAG). The latter had a much wider support base.

"WAG started with a double force: people who felt very strongly about the issue of maternity care and people who were opposing the closure purely for reasons of local loyalty; Bletchley was not like Newport Pagnell for it has always accepted Milton Keynes as the dominant centre. There were also people who simply felt that the DHA needed to be sent back to do its homework because the information provided in the consultation document was so inaccurate. At the time we did not work to get the support from the professionals involved. We already had a GP on our committee and we thought they would fight for themselves. No individual midwife was prepared to come forward and be seen on our side. We believed they were instructed from the top not to show public support for the campaign"

Founder member WAG

WAG had a remarkably high quality and resourceful membership.

"They had many bright and energetic people on their side, some of them lecturing at the Open University. They had access to all sorts of resources and they were assisted by specialists in communication and by a professional statistician. They devised a computer programme showing what would happen if our planning assumptions were wrong. Locally we did not have such expertise and we were in real difficulty with some of their statistical arguments"

District Treasurer

WAG's reasoning to oppose the District's proposals was twofold: (1) the number of beds in the DGH would

not fit the future demand, and (2) the units were local, friendly, low tech, and had a good reputation.

The expertise available had a significant impact on the campaign strategy adopted by the opponents to the closure. Their main effort went into demonstrating that the District's birth projections were erroneous. The Action Groups also led a very intensive public relations campaign. They organised a series of press events such as finding the first baby born at the Westbury to support the fight to keep it open. They also gathered over 6000 petition signatures. They also lobbied the local councillors, the Authorities, and the CHC.

Both the District and the CHC had their own ideas about the issues at stake. The CHC was inclined to compromise and hesitated for some time before making up its mind.

"Our response evolved over time. We did not know we were going to oppose both closures until the night of the second public meeting. Having discussed the District's proposals in our sub-group, we then went back to the full CHC meeting. We put forward a proposal advocated by the NCT representative on the CHC who suggested that we should accept the closure of the Westbury Maternity Home but oppose the change of use of Bletchley GPMU. It was a compromise which fitted the mood of the committee. On one hand, the members of the committee felt that the new CHC ought to flex its muscles and they did not want to go along with all the district's proposals. On the other hand they did not want to the rock the boat unnecessarily."

CHC Chairman

The CHC members were broadly in agreement with the compromise proposal. Nevertheless, they finally decided to oppose both closures.

"At the very last minute an amendment to the effect that the Council would oppose the closure of both units was mooted and passed with a very narrow majority. The same person who advocated the compromise motion seconded its amendment. That suggests the ambivalence which was around. There was a bit of the CHC having to decide to test its power or to sit back and be a rabbit organisation"

Founder member WAG

Having decided to oppose the proposals, the CHC then had to justify its position and to adopt a strategy.

"The amendment covers a lot of points. We then really had to start doing our homework. There were a whole series of reasons for opposing the proposals. They reflected the coalition of different interests that was put together to oppose the closure. There was no clear majority on anyone of those arguments to oppose the closure. The arguments were falling into three categories: (1) statistics, (2) local politics and (3) quality of maternity care. The latter was much harder to argue. It was absolutely vital to be seen to be doing this properly and to be respected for what we were doing. WAG was a very professional operation. We hitched on them. We felt that we had the expertise via WAG to concentrate on the statistical level. We did try to beat the Authority at its own game."

CHC Chairman

The CHC proposed retaining both GP units and reducing the number of maternity beds in the DGH to 53. The Council declined to make any recommendations on the use

of the remaining beds. They also proposed selling bits of land surrounding the Westbury building in order to meet financial pressures.

The Regional Planning Team (RPT) considered the proposal in January 1983 in order to appraise the District of their views before the closure of the consultation. The Regional Planning Officers expressed concern about the District's birth projections. They also questioned the associated move of transferring GP medical beds from the Community Hospital to Bletchley. Nevertheless, in principle they supported the proposals.

The maternity working group met on two occasions following the closure of the consultation period to re-examine the proposals in the light of comments received from objectors, as well as fresh statistical information provided by the RHA's statistician and planning team. The working party accepted that the number of GP beds might be inadequate to meet the demand. However they felt that the total of 69 beds would be sufficient and that 12 shared-use beds between consultant obstetricians and GPs would allow for increasing the size of the GP unit according to need. A new document supporting the proposals was then made.

The summary of responses to the proposals showed that along with the CHC and the Action Groups, Milton

Keynes Borough Council and the local medical committee were against the closures. The JTUC and the Royal College of Midwives were in favour of the proposals.

At its meeting on 1st March 1983, the DHA resolved to reject the CHC counter-proposal and to support the closure of both GPMUs, despite the CHC Chairman's request for an opportunity to put the new document to the CHC.

"The paper tabled at the DHA meeting varied considerably from the initial consultation document. It was presented in the form of two separate proposals, the bed allocation was adjusted, it was supported by a financial paper, the statistical evidence was revised, and the new paper was supported by a submission from the Regional Statistician. Our Chairman received this wad of paper late in the evening of the day before the meeting. He asked for an extra month to consider it but this request was refused and the decision was carried forward. To be honest, the important thing for us was not so much the comments we had to make on the proposals as to establish what our relationship with the DHA should be and the way they should treat us. Not only must they receive what we have to say but they must be prepared to tell us what they think about our response. It must be a two way process."

ex-Chairman of the CHC Maternity
and Child Care Group

Having decided to accept the proposals, the DHA referred the proposals to the RHA as per normal consultation procedures.

The CHC and the Action Groups criticised the Authority for denying them more time to revise the

"new" document. They urged the RHA to direct the DHA to consult further.

The Regional Manager took the view that in view of the forthcoming National election, Ministers would want to be absolutely sure that local consultations had been appropriate and effective. Since this was more likely to be challenged, it would be better to allow an additional period to the CHC to make further comments. In April 1983, the DHA agreed to allocate further time to conclude consultation with the CHC.

According to the CHC, the major problem arose out of the design of the new DGH. Therefore, the CHC's strategy called for the Phase I DGH building to be physically modified to separate off the 16 beds into a distinct ward for use by gynaecological patients only.

"The key mistake was the decision to build-in provision for 69 beds on the assumption that 16 of these could somehow be temporarily used for gynaecological patients. Together with another policy decision not to risk impairing completion of the DGH contract by varying its specifications in any way before handover, this reversal of an assumption made at a relatively early stage of the decision process has led the DHA to formulate its proposals"

CHC Chairman

Ultimately, the CHC reasserted its previous counter-proposal.

On the 3rd May 1983, the DHA resolved by a majority of 13 to 1 that it should reaffirm its previous decision.

"We said the right thing to do is to use the new facility. It is mad to have an expensive new asset partly closed and to continue to use an uneconomical and less satisfactory facility. Having fought that many years to get a DGH in Milton Keynes and having invested that much money in the new hospital, we should use it. We did not accept that counter-proposal."

District Administrator

The Conclusion of the Bletchley and Westbury Proposals

The RTO analysed the DHA's proposals in June 1983. After having reviewed the main arguments used by the opponents as well as the DHA's replies, the Regional Officers concluded that the statistical and safety arguments were fairly marginal whilst the full financial savings were not achievable in a very near future any way. Therefore the RTO directed its attention to the strategy to introduce a specialist maternity service into Milton Keynes.

The RTO supported the closure of Westbury Maternity Home. Although supporting the closure of the Bletchley GPMU, the RMO vetoed the proposal to move the GP's medical beds from the Community Hospital on the DGH site to Bletchley.

"The RMO felt strongly that Milton Keynes DGH would be different from a traditional hospital in that it would be much more GP

oriented. Region has always been committed to the concept of community hospital and the removal of all GP medical patients was seen as entailing destruction of the principle upon which the hospital was built. The RMO took the view that means of increasing rather than diminishing the GP's DGH presence were to be found."

Regional Planning Administrator

The RTO also requested the DHA to proceed towards closure much more slowly. The strategy proposed involved running the two GPMUs in parallel to the new GP unit, integrated with the DGH specialist, for at least an overlap period of a year so that GPs and midwives could compare experience.

The RHA approved the RTO's recommendations on July 14 and sought the Secretary of State's approval to close Bletchley and Westbury for maternity purposes.

Since no objection was raised by any Regional Officer during the consultation period, the District Officers were shocked by the regional proposal to keep the GP medical beds on the DGH site.

"Region did not know what they were doing at that time. They were very fragmented. This is where a lot of the Commissioning Team problems came from. Whilst the proposal might be considered a reasonable option in theory, in reality it was impractical. Not only the allocation of beds between specialities in the DGH was still an unresolved problem but the strategy involved staffing three GP units, two of them for an interim period only. The recruiting policy allowed staff to ask to be considered for transfer to the new hospital. All the staff at both Bletchley and Westbury, with one exception, were requesting transfer. An

additional problem related to the maintenance of the Westbury building. Another problem was the increased running cost etc."

Director of Maternity Nursing Service and
Commissioning Team Member

The opponents to the closures celebrated the RHA decision as a victory.

"We saw it as a victory. We knew we could not really fight the closure any more but we welcomed the RHA's idea of having a monitoring period during which time some research would have been done into the use of the units and maternity services in general. That would also have provided some time to strengthen our campaign and to prove that the units really were popular. The RHA decision involved the complete closure of Bletchley as opposed to its change of use. That was one step further than the District's proposal. We have never been consulted on the total closure of Bletchley. There was an argument there to be made. However, there was not the energy to start all over again. We felt we presented our case and it was up to the Minister to decide."

Coordinator WAG

The District Officers met the RMO and her colleagues to try to find some way of modifying the acute bed allocation in order to retain at least a few GP medical beds in Phase I of the DGH. Many possibilities were investigated but, at the end of October 1983, none of them was considered satisfactory in the long term. At the District Review Meeting it was suggested that the GP unit at Westbury should be retained in the short term in parallel to the DGH. A

feasibility study was undertaken by the Chief Nursing Officer.

A meeting between a delegation of opponents to the proposals and the Minister was mooted by the local MP, Mr Bill Benyon. At the meeting held on 15th December 1983, the delegates insisted that several years were needed to let the new hospital become established and to have a reasonable monitoring period.

The Secretary of State, Mr Kenneth Clarke, approved the closures in January 1984. He requested that the units should be closed within 3-4 months following the opening of the new DGH facilities.

The RMO reluctantly agreed to withdraw her objection to the transfer of GP beds to Bletchley as a temporary measure. She insisted on the need to restore the Community Hospital to a GP function following the opening of Phase II of the DGH.

The DHA opened the first 28 DGH maternity beds on 8th May 1984. In the first two months the workload built up more rapidly than expected. The CHC agreed to advance the closures.

"Once the decision was taken to close the GPMUs, the CHC supported the proposals and made them work. They were very good all along."

District Administrator

Bletchley GPMU closed on 11th June 1984 and Westbury Maternity Home on 1st July 1984.

"The outcome has been a lot better respect and working relationship between our two bodies. I do not think the community could have run a better campaign. As far as the CHC is concerned, yes, we could say that it has been quite successful."

CHC Chairman

The CHC's Survey of Maternity Services assessing the satisfaction of mothers who used the services offered by the DGH during its first year concluded that most mothers were basically satisfied with the service being provided. The evaluation carried out by the DGH also stressed the success of the unit in its first year pointing out that good relationships had been built up between the staff of the unit and the various voluntary bodies who opposed the proposals.

"The new Unit is quite well regarded as far as delivery goes; but there have been, and will continue to be, problems of having enough beds and staff to provide quality post-natal care in both the hospital and the community."

Founder member of WAG

Concluding Discussion

The implementation of the Milton Keynes DHA's proposal to close the Westbury Maternity Home featured strong local resistance while the concurrent proposal to change the use of the Bletchley GPMU was virtually

unopposed by the local community. Ultimately, the closure of both facilities was regarded as successful, although the proposals were formally objected to by the CHC. Why was it so, and why was the previous proposal to close the Westbury Maternity Home unsuccessful?

The Pressure for Closure

This case-study illustrates empirically how local strategy can be developed in response to a number of relatively independent frontline problems (Barrett and Hill, 1984; Ferlie and Pettigrew, 1990). The combined effect of the commissioning of the new DGH, the need to accommodate an additional speciality into it, the deteriorating condition of the Westbury Maternity Home and its need for up-grading work, triggered off a series of decisions and actions which, progressively, led to the centralisation of all maternity beds.

The evidence indicates that national policy and regional strategy were used once the decisions had already been made by the district officers in order to enhance legitimacy for the proposals. On the backcloth of the District Review System, the new DMT members and the District Treasurer in particular were anxious to demonstrate their capability to manage the local services. Their concern to be seen by the Region as doing the right things in the proper way was an

important factor in speeding up the centralisation of maternity services in the district. The data rejects the conventional assumption that the central policy is the starting point for implementation (Fudge and Barrett, 1984) and, therefore, challenges the traditional top-down view of implementation. The case study suggests that policy can be generated at local level and that local circumstances and strategies can trigger implementation.

A New Context for Closure

The Westbury Maternity Home had had a relatively low level of occupancy and few deliveries. A number of contextual influences however acted as forces of inertia and secured its continuance. Until 1982 the facility was located outside the limit of the district responsible for running the local health care services. This structural feature made it difficult for the district concerned to uphold the closure proposal in the face of local public opposition.

Because of the rapid growth of population and the high child birth rate in the district of Milton Keynes as a whole, the possibility of a future increase in the statistics was a rational and logically admissible scenario; as Hunter (1983) pointed out, "rationality is a legitimising characteristic" (p.58). This convincing

argument was played with full vigour by the opponents to the various proposals.

There were only a few local health care services available and the Milton Keynes community was already thoroughly pursuing claims for more local health care services. The Westbury Maternity Home became a symbol in the community. This granted powerful support to the maternity home not only from the residents in Newport Pagnell but from other important influencers living within the limits of the future District.

The Westbury data illustrates that change in context can critically alter the base of power of the potential influencers and provide, in this case, the conditions to legitimate the closure. The inception of the Milton Keynes DHA helped create the political will for implementation, and the decision to build a new DGH in Milton Keynes confined the opposition to the people of Newport Pagnell.

The case-study suggests that the contrast in the response to the proposals between Bletchley and Newport Pagnell can also be attributed to the nature of the district. Milton Keynes incorporated Bletchley but not Newport Pagnell which remained geographically separated from the new city. Milton Keynes has undergone major social and demographic changes. This can be associated with the lack of opposition in Bletchley. In the same

way as in the Amersham case-study, the rivalry between the traditional market town of Newport Pagnell and Milton Keynes played an important part in setting up a powerful coalition to oppose the closure of the maternity home.

Combining Closure and Redevelopment

The proposals themselves played a critical part in the contrasting local response between Bletchley and Newport Pagnell. The evidence shows that a closure proposal can be more difficult to implement than a change of use of local facilities. Compared with the Newport Pagnell community, the community in Bletchley felt that it was not losing but gaining by the implementation of the proposal. Clearly, the provision of a community hospital in Bletchley contributed convincingly to those with blocking power and the local GPs, in particular, in not resisting the proposal. The case study illustrates once more the role of incentive in putting together a coalition for change, in this case an alliance between the District Officer, the GP in Bletchley, and the staff who prevailed over relatively powerless local NCT representatives. As Kogan and Simon (1978) indicated:

"By being able to demonstrate that closure is part of a process of working towards redevelopment of resources to provide a service which is better aligned to recognised

needs, the community may feel that it is not losing but gaining." (p. 174)

The Approach to Implementation

The managerial actions were no different in Bletchley than in Newport Pagnell. The actions of the officers conform with the decision-making perspective (see Chapter two), which points to a rational/analytical decision-making process as the key element to successful implementation. The officers did not attempt to reduce the likelihood of local opposition from the community, nor did they take any special steps to secure either the CHC or the GPs support for the proposals. In Hardy's (1985) terms "since no threat was perceived, managers felt no need to develop unobtrusive measures" (p. 104). The opening of the new DGH was perceived by the officers as a legitimate reason for the withdrawal of services and the Minister's approval was expected. In this case, it is clear that the context of the opening of the new DGH played a significant part in the implementation process.

The Will, Skills and Power of the Opposition

The CHC Chairman's concern for establishing the status of its Council was the most important factor in the CHC decision to oppose the proposals. The

consultation was regarded by the CHC as an important test-case with significant implications for its future relationship with the DHA and for the public perception of its function. Had the CHC already been well established, it is conceivable that no formal objection would have been raised to the closure of the maternity home as initially recommended by its Maternity Advisory Committee.

Unlike the CHC in Wycombe, the CHC in Milton Keynes was, however, reluctant to offer more than rational arguments to keep the GPMUs open. The case-study points to the personality and style of the CHC chairman as a key factor in understanding the action of the CHC. It also suggests that institutional pressures and societal norms of rationality, in particular, can lead both the DHA and the CHC to adopt actions and languages that are viewed as rational in order to be perceived as responsible and legitimate in promoting and in resisting implementation (Meyer and Rowan, 1977; Langley, 1989). This supports the view that visibility in decision-making can force the use of more acceptable and legitimate criteria to justify the decisions and actions (Pfeffer, 1981).

Finally, the evidence relating to the RHA's decision not to support the DHA proposal to change the use of the Bletchley GPMU, as well as its counter-

proposal to run concurrently the three district maternity services, tends to confirm the findings of Kogan et al (1978) and Butts et al (1981) that DHSS and RHAs' decision criteria often differ to those of the districts which are more concerned with the operational problems of implementing change.

Summary and Conclusions

In summary, the case-study questions the conventional view of implementation as a simple transmission of policy into action. In this case, the DHSS policy was re-discovered after the process of implementation had begun and used by the authority to add legitimacy to the closure proposal. The dominant feature of the case is that the closures were part of a whole series of actions related to the commissioning of the new DGH. The evidence shows clearly the influence of the local context and particularly of the history and geographical characteristics, the competition between localities, and the local politics on the reaction to the closure proposals.

CHAPTER NINE

Isebrook GP Maternity Unit and Children's Ward

The fourth case-study documents the closure of the whole GPMU at Isebrook Hospital (IH) in Wellingborough by Kettering DHA. The proposal to close the maternity unit was one of the main items included in a package of cuts in services which also contained a proposal to close the paediatric ward. The CHC did not object to the closure of the maternity unit and the proposal was implemented. The closure of the paediatric ward was much more controversial. Ultimately a Joint working group between the Authority and the Community Health Council (CHC) agreed to transfer the paediatric service from Isebrook Hospital to the Kettering District General Hospital (DGH).

The Profile of the District and Unit Under Study

Kettering DHA is located in the North and East of Northamptonshire. It is situated within the East Midlands compared with the rest of the Oxford RHA which lies within the prosperous South East. Therefore the socio-economic structure of the District is closer to the profile of the industrial Midlands than to the rest of Oxford RHA. There is a greater proportion of skilled and semi-skilled manual workers compared with other Oxford Districts. The population of

Wellingborough was less educated, not as organised nor as vociferous as in Amersham. The district comprises three main centres of population based in the North on Corby, in the centre on Kettering, and in the South on Wellingborough. Although unemployment has fallen considerably in the last few years, particularly in Corby, the District still has the highest unemployment rate in the Region.

Kettering and Wellingborough were traditionally centres of the British footwear industry. However the importation of footwear from abroad eroded their importance. Wellingborough has been granted enterprise zone status. Kettering is a market town which is the focus of the surrounding rural area. The acute services were almost entirely concentrated on one site at Kettering DGH (533 beds), largely in new buildings. All other hospitals were predominantly used for the care of the elderly. In terms of acute health care services, the centrality of Kettering was generally accepted and the people living in Wellingborough were accustomed to traveling there for most of their health needs. It was also recognised in the 1962 Hospital Plan.

"Kettering was second only to Northampton on the list of the important centres of population in Northamptonshire. At the time the hospital plan was prepared it was projected that by the mid-1970s the Wellingborough population would merely

compare with the population already in Kettering in the early 1960s. Major growth was expected in the North of the District rather than in Wellingborough. However, there had been speculation within the County that the population growth would be in the corridor between Northampton and Wellingborough. Therefore there were exploratory discussions to provide a new DGH in Wellingborough. The anticipated population growth did not happen and the bed requirement has been reduced significantly. The case for a second DGH in the South of the District has completely disappeared. This fact is now accepted by the local population in terms of acute services but not totally accepted in terms of the care for the elderly."

Administration and Planning Manager

Kettering Health District had a population which, in 1984, stood at about 255,000. The population was projected to rise to 270,000 in 1994. The increase was estimated at about 7% against a Regional average of nearly 11% and a national average of 2.5% over the same period.

The Standard Mortality Ratios (SMRs) indicate that the population of the District is slightly healthier than the population of England & Wales. Nevertheless the District is among the less healthy in the Region. It has only 2.5% fewer deaths than would be expected from the age/sex structure. For several years, the District has had the highest Perinatal Mortality Ratio (PMR) in the Region and the PMR of the Isebrook GPMU was the worst in the Region. This had a significant impact on the district strategy for maternity services

which traditionally suggested retaining all maternity beds in Kettering as well as in Wellingborough, contrary to RHA guidance.

"There was a general view within the District that we should provide services on a distributed base where it was possible. We always valued accessibility of services very highly. The strategy for maternity services was made with that in mind. Beside the KGH maternity unit would not have been able to cope with an increased workload without any risk of increasing further the PMR. We were not providing a backup community service so to operate a more intensive use of the maternity beds in Kettering"

Administration and Planning Manager

However the Regional Strategic Plan 1984-1994 restated the need to address the reduction and distribution of maternity beds in the District.

The strategy of development of acute and priority services pursued by the District since the early 1960s could be divided into four periods:

- (1) 1962 to 1977, a period of expansion of acute services based on the development of Kettering DGH site phases I and II and the opening of out-patient and day care facilities;
- (2) 1977 to 1985, a period of rationalisation on the DGH site and development of geriatric as well EMI and psychogeriatric services and on various peripheral sites using some of the existing buildings freed by the opening of the DGH Phase II;
- (3) 1985 to 1987, a period of serious financial difficulties;

- (4) 1987 to 1990, a period of consolidation of acute services and rapid development of community based MI and MH services.

The major impact of the District Strategy 1984-1994 was to ensure that the population ceases to rely upon services in Northampton for Mentally Infirm, Mentally Handicapped, and Elderly Mentally Infirm.

The Management of the District

From 1974 to 1982 the District had experienced virtually no change on the DMT. The only senior officer who left the DMT was the District Nursing Officer (DNO) who retired in 1981 to be replaced by the current Chief Nursing Officer.

The 1982 re-organisation brought some senior officer changes to the DMT with the departure of both the District Medical Officer (DMO) and the District Treasurer (DT). The vacancies were filled by experienced officers from Oxfordshire and from Berkshire AHAs respectively. There was, however, no lack of continuity at top-management level and the proposals were carried on in the light of the past history of the issue.

In 1985, the introduction of general management brought about some changes in the Kettering DHA. However it did not bring many new faces to the District. The District Administrator was appointed

District General Manager (DGM). He retained with him the DMO and the Chief Nursing Officer (CNO). All three new Unit General Managers (UGM) brought by the implementation of the Griffiths' report had lengthy service in the District as members of the medical staff and district officers. The District Treasurer was the only outside candidate to join the new District Management Board (DMB) which took over the District Management Team (DMT) as the key management structure following the implementation of the Griffiths' report. The district senior officers did not interpret general management as having radically changed the style and process of management in the district.

Before being appointed District Administrator in 1974, the current DGM was already involved in the management of the local health services. He was the Deputy Group Secretary to the Northampton Hospital Management Committee. He has been leading the District ever since.

The key factors in this case resolved around a politically aware DGM. He was anxious to spread any reductions in services as widely as possible throughout the District and across the range of services provided by the Authority but he was also anxious to see the strategic developments achieved. The DGM was ready to consider all alternative proposals yet prepared to take

an unpopular decision if no agreeable compromise could be found. The favoured managerial style in the District was one of approaching the problems in stages with an element of opportunism.

"There is a limit to the number of measures that can be implemented at once. When one stage has been completed you have got a more precise measure of what needs doing further ... In the short term what can be done under the particular set of circumstances might not always match precisely with the plans. For instance, in the case of the closure of the children's ward the path was drawn only in the light of sign posts that appeared fortuitously. There was no sense in which the final outcome was the perceived objective when the whole exercise started. Standing back, from the Authority point of view it could still be seen as a compromise. Nevertheless the service now provided is clearly improved."

District General Manager

The Chairman of the DHA played a rather less conspicuous part in directing the closure proposals than his counterpart in Wycombe DHA did in closing the Amersham GPMU. The Chairman was a local businessman who retired in March 1989. His appointment was the latest of a long series of involvement in the administration of the local health care services which started in the mid-1960s. The Chairman was particularly concerned by the public relations and by the promotion of the Authority. He was seen as being involved in the running of the Authority while keeping a largely non-executive stance.

"The Chairman had a fair degree of involvement. He certainly ensured that he kept out of the day to day management of the District. He wanted the District to run as smoothly as possible. Making rough water was not usually his style"

DMG Member

The Profile of the Unit Under Study

The older buildings on the site of the hospital were built in 1835 and formed part of the Wellingborough Union Workhouse. The hospital did not, however, have the same sort of emotional appeal in the local community as the Amersham General Hospital in Wycombe. In 1948, at the inception of the NHS, the institution was renamed the Wellingborough Park Hospital after the city park which is located nearby. As it had done prior to 1948, the hospital provided residential accommodation for the elderly, together with a small maternity service.

Throughout the 1950s and the 1960s the hospital was a Joint User Establishment managed between the District Hospital Management Committee and the County Council. In the 1960s the residential accommodation was gradually phased out as new homes for the elderly were built by the County Council. By the late 1960s all the hospital residential accommodation had been closed and the old Workhouse buildings vacated. They are still unoccupied.

In the early 1970s major developments took place. New buildings were constructed and new geriatric services and facilities were added to the hospital. Furthermore an out-patient department was opened. The Hospital was renamed Isebrook Hospital after the River Ise which runs through the town. The change was intended to stress the new developments which were taking place at the hospital. It was also an attempt to break with the old hospice image associated with Park Hospital, particularly in the mind of the local elderly population. The new name of the hospital negated many of its historical associations, which in any case were concerned with the care of the elderly as opposed to the obstetric and maternity services.

In 1972 the closure of a small local acute hospital resulted in the paediatric service being transferred to Isebrook Hospital.

"The transfer of the paediatric ward to Park Hospital (Isebrook) was made for two reasons. Firstly, paediatric had traditionally been seen in this district as a local service. Secondly, various wards were being vacated on the Park Hospital (Isebrook) site. This allowed paediatrics to be retained in Wellingborough without any substantial capital investment. The opening of the paediatric ward at Isebrook was the result of opportunism as much as anything."

Administration and Planning Manager

In 1984, Isebrook GPMU had 14 in-patient beds and three delivery rooms. The maternity unit undertook

177 deliveries out of a District total of 3107. The GPMU also received 514 post-natal transfers from Kettering DGH. There were on average 5.7 occupied beds and 2.5 discharges per day. The average length of stay was three days (Table 9-0).

Table 9-0

Obstetric and GP Maternity Vital Statistics
Kettering DHA, 1981-1984

	1981	1982	1983	1984
<hr/>				
<u>%beds occupied*</u>				
Kettering DGH	66	70	70	63
Isebrook GPMU	39	32	39	41
<hr/>				
<u>Discharges</u>				
Kettering DGH	3270	3342	3162	3293
Isebrook GPMU	917	851	757	691
<hr/>				
<u>Length of Stay</u>				
Kettering DGH	4.4	4.5	4.2	4.0
Isebrook GPMU	3.1	2.8	2.8	3.0
<hr/>				
<u>Births</u>				
Kettering DGH	2741	2837	2715	2696
Isebrook GPMU	307	261	222	177
<hr/>				

* Number of beds:

KGH: 1981 = 60, 1982 = 59, 1983 = 52, 1984 = 58

Isebrook GPMU: 1981 - 82 = 20, 1983 = 15, 1984 = 14

Source: ORHA, Hospital Statistics, 1981-1984.

Kettering has a long tradition in obstetrics. Up to the opening of the DGH Phase II in 1976 the main District obstetric service was provided by St Mary's Hospital in Kettering. The closure of the St Mary's Hospital allowed the opening of the DGH.

The District used to have another GPMU of 20 beds and 4 delivery rooms which formed part of the Diagnostic Centre in Corby. Like the closure of Isebrook GPMU, the proposal to close the Corby GPMU was mooted as a "temporary" measure undertaken to deal with financial difficulties. The Authority wished to bring the unit back into use but, as the District Administrator indicated, not necessarily for maternity purposes.

There was considerable opposition to the closure of the Corby GPMU particularly from a large number of GPs in the locality and from the midwives and nursing staff of the unit. Initially the CHC, and particularly its Hospital Committee, agreed with the change of use of the GPMU but further public pressure led the CHC to alter its original decision and to propose, in conjunction with the staff and the GPs, retaining a small maternity suite utilising the remaining beds for other general medical purposes.

The CHC counter-proposal was rejected and the proposal approved by the RHA. The RHA referred the

proposal to the Secretary of State who, in October 1977, approved the closure of the Corby GPMU. In February 1978, the maternity services were transferred to the new maternity ward in the DGH in Kettering.

This concludes the profile of the district and unit under study. The next section presents an overview of the process and outcome of the proposal to close both the children's ward and the maternity unit at Isebrook Hospital.

The Closure of Isebrook GPMU: An Overview

Kettering DHA was facing a different problem than the other DHAs described in the previous chapters: bringing its income and expenditure quickly into balance. The proposal to close Isebrook GPMU was one of the main items included in a single package of cuts in services put forward by the District General Manager in July 1985. The package also contained a proposal to close the paediatric ward.

As a result of the implementation of a number of planned developments, combined with the replacement and the addition of new consultants, the general level of activities in the District was running ahead of the predicted level. Therefore, the costs of providing the services were exceeding the District revenues. The original proposal concerns the temporary closure of

both services. They were later changed into permanent closure proposals.

The proposal to close the GPMU did not come as much of a shock to the medical staff as the closure of the Paediatric ward did. The latter caused the resignation of the medical representative, one of the consultant paediatricians at IH, from the DHA Board. The news came upon the midwives and nurses of the maternity unit as a shock. However, staff resistance and the Trade Unions opposition to the closure faded out rapidly.

A "Save Isebrook Campaign" (SIC) was launched by two mothers of mentally handicapped children who regularly used the Paediatric ward. The public opposition campaign welcomed the supplementary pressure put on the District package of cuts in services by the opponents to the closure of the GPMU. However, the maternity unit was seen as a side issue.

The District was a marginal constituency held by the Government. The closures swiftly became a political issue dominated by the problems of funding the NHS (see Chapter five). The Chair of SIC was taken over by a Labour prospective parliamentary candidate and the campaign was supported by the local paper, The Evening Telegraph. Soon a meeting between the Minister of Health, Mr Kenneth Clarke, and a delegation of

people against the closure of either one or the other wards was instigated by the local conservative MP, Mr Peter Fry.

The Minister intervened. The opponents to the closure of the Paediatric ward used this political support to uphold their appeal to save the children's ward but the opponents to the closure of the GPMU were unable to establish enough legitimacy for their cause locally and did not benefit from it.

The District pressed on with the temporary closure of the GPMU and then moved forward to the permanent closure with minimum opposition. At the outset the CHC opposed the District package of reductions of services. However both the Chairman of the CHC and its Secretary were broadly subscribing to the closure of the GPMU and to the rationalisation of the paediatric ward.

Ultimately a new proposal mooted by a Joint DHA/CHC working group was put forward which transferred the nucleus of the paediatric services to the DGH. The latter proposal was suggested by the CHC as well as by the paediatricians.

"Our original intention was to close the whole paediatric ward. It is only fair to acknowledge that the closure of the Paediatric ward was an example of the consultation process serving a very useful purpose and not being just a formality"

DHA Chairman

Table 9-1 presents the diary of the principal events.

Table 9-1

Wellingborough Isebrook GPMU Case-Study

Diary of Principal Events

Closure of (A) the GPMU and (B) the Paediatric Ward

1985

July

A.B. Announcement of the temporary closures through the DHA approval of the DGM's package of measures to retain the level of expenditure;

B. Resignation of the consultant paediatrician from the DHA Board. The Medical Advisory Committee and the consultant paediatricians refused all collaboration;

A.B. The local MP opposed the closures;

A.B. The CHC opposed the scheme;

B. SIC was launched and held two public meetings;

A.B. Meeting between a delegation of opponents and the Minister of Health;

August

A.B. The Minister requested from the DHA a clear statement about (1) the alternative facilities before either closure goes ahead and (2) whether the closures are to be temporary or permanent;

B. Consultation of parents on the alternative facilities to the IH children's ward;

1985

September

A. Temporary closure of the GPMU;

A.B. The Minister pressed the DHA to decide as quickly as possible the long-term future of both wards;

(Table 9-1 continued)

October	B.	Details of offers made to the parents sent to the Minister;
	B.	Consultant paediatricians informed the Minister that the alternatives were not suitable but recommended a reduction of 4 to 6 beds;
	B.	The CHC asked for full consultation to be implemented;
November	B.	The Chairman recommended the permanent closure of the paediatric ward. As a result, there was then no decision for the Minister to take on the original proposal;
1986 January	B.	Consultation paper on permanent closure of the paediatric ward;
February	A.	Consultation paper on making permanent the GPMU temporary closure;
May	B.	The CHC opposed the closure of the paediatric ward but a Joint CHC/DHA Working Party (JWP) was set up;
July	B.	JWP recommended the transfer of 6 paediatric beds to KGH;
	B.	The CHC withdrew its opposition to the paediatric ward closure;
September	A.	CHC decision not to oppose the closure of the GPMU.

The Proposal

The previous section presented an overview of the process and the outcome of the proposal to close the GPMU and the Paediatric ward at Isebrook Hospital. The next section details the genesis, the development, and the conclusion of these proposals.

The Genesis of the Isebrook GPMU Closure Proposal

The Isebrook GPMU had been a candidate for closure on several occasions before a formal proposal was finally put forward. In 1976, in view of the opening of Phase II of the DGH, the DMT considered the closure of the 26 maternity beds in Wellingborough in order to bring more of the new maternity beds into use at the Kettering DGH. Ultimately, the closure of the 20 maternity beds in Corby was considered more appropriate by the AHA officers. However 6 maternity beds were closed at IH.

In 1982, the closure of the Isebrook GPMU was the first item on a list of some 28 possible cuts in services sent by the DMT to the CHC, the advisory committees, and all other interested bodies for consultation. The district officers were keen to secure the maximum degree of cooperation from all interested parties. Details of the District financial position were attached to the list of cutbacks. One of the subsidiary objectives of that consultation was to ensure that the seriousness of the financial situation was brought home to all staff and the public. Two stages were suggested to reduce expenditure: (1) bring the income and expenditure into balance; and then, if necessary (2) initiate further savings to reduce the accumulated overspending.

The size of the accumulated over-spending was one of the main disagreements between the District and the Region.

"Before 1982, Northampton and Kettering were two districts under the umbrella of the Northamptonshire AHA. When the restructuring took place we expected that the AHA over-expenditure would be ironed out. We spent many years arguing our case with the RHA. We have got to reduce an over-spend which was not of our own making in the first instance. We should not have inherited an over-spent budget when we became independent"

District Nursing Officer

The revenue allocation was also an important controversy between the District and the Region. Up to 1985, the District Officers were working under the assumption that they had a legitimate claim for additional monies from the Region and they deferred the implementation of the closures. There was no time pressure and no sense of urgency in cutting back the services. The Authority was cautious not to jeopardise its campaign for additional monies from Region in implementing change.

"When we took over from the AHA we anticipated that we would get our correct proportion of the budget. However we did not get our fair share of the cake as it were. We informed the Region extensively about this. The general feeling in the District was that we did not really need to close beds since the Regional figures would eventually come out and show that the District was well under-funded and we would get additional money. We planned a series of developments assuming that this would happen. We still

suspect that if they were ever to produce good quality RAWP targets we really ought to be shown to be below any reasonable level."

District Deputy Treasurer

The candidates for closure and the possible closure of the GPMU in particular were, however, well flagged up. On the list of possible cuts in services issued in 1982 for consultation, the closure of the GPMU stood side by side with proposals which proved to be much more controversial. For instance the closure of the whole Corby Community Hospital, as well as a major part of Rushden Hospital, was considered. The closure of a general surgical ward and an operating theatre at KGH as well as the closure of the paediatric ward at IH were also among the proposals considered.

Ultimately, Isebrook GPMU was maintained though not completely. As an alternative option arising out of the consultation, it was decided to rationalise further the maternity services closing 6 out of the remaining 20 maternity beds at IH and reducing the staff levels at KGH maternity unit.

"The medical and nursing staff felt strongly that it was necessary to keep the unit open. Isebrook was used as a "safety valve" when the pressure was intolerable at Kettering Maternity Unit. It was feared that a larger workload at Kettering might increase the PMR. The occupancy of the GPMU was low but with the commitment of the consultants and GPs to use Isebrook it was thought that there was enough grounds for retaining a local base service. Last, but not least, the savings resulting from the rationalisation were

estimated approximately half of those which would be realised by closing completely the GPMU. We were presented with an opportunity to get the savings without closing the services. That was a quite workable compromise."

District Medical Officer

These changes were implemented in 1983. According to the District Strategic Plan issued in July 1984, the changes brought the District maternity services into balance. Contrary to Regional Guidelines, the plan did not take into account any further closure of maternity beds during the period 1984-1994.

"It is thought that this balance is about right, and will not be altered until adequate experience is gained, over several years. The District therefore intends to retain one of the GP units separate from the consultant unit, contrary to RHA guidance. In any case the beds presently available could not accommodate the number of births which take place in Isebrook Hospital, Wellingborough. With good selection, a geographically separate GP unit has a useful part to play and satisfies both midwives and mothers' expectations."

District Strategy 1984-1994

In fact, the District Strategy was in disagreement with the Regional Guidelines on all but the acute services bed targets.

The opportunity to reconsider the future of the maternity services at Isebrook Hospital came up at a DHA special meeting held in June 1985 to consider the

financial situation. The District was providing services at a much more rapid rate than was planned.

"All the evidence showed that we were an efficient district with a high level of patient activity and no sign that we were extravagant or wasteful. However, we were doing more work than we could afford. We were doing a good job effectively but cannot meet the cost of all our activity."

District General Manager

The overall financial position was becoming more difficult.

"There were pressures to take on new staff and to do extra work without seeing the book balance. We replaced a number of consultants who had their old but cost effective way to work. The new consultants who came along were much more enthusiastic, more active, and more energetic but less cost effective. They were able to have a greater work throughput. We also implemented a number of desirable developments such as the hip replacement service which had a much higher volume than expected. Altogether we did not have the money to support that workload."

District Deputy Treasurer

The budget report was forecasting a potential accumulated over-spending of over a million pounds by March 1986.

"We inherited an over-spend of £200,000 on the break out of the AHA and we came out of our first year with an over-spending of £300,000. The next year it went up to £560,000 and it was threatening to reach over a million pounds. It was that creeping up process that triggered the closures."

Administration and Planning Officer

When the district's assumption that more money from the Region would be available was finally being proved wrong the Officers considered closing some of the services.

"When it became obvious that we were moving into a different climate, since there was no additional money to come, we decided that it was better to cut our services. The children's ward at Isebrook used to have very few children in there and the maternity unit was under-used. Had the closure of the children's ward been put forward in 1982 there would have been less opposition. The occupancy and the staffing level were very low and the sister was retiring. It was used essentially to provide relief care for handicapped children. The new sister developed the treatment of children with difficult behaviour providing a new legitimacy to the ward. We missed the opportunity. We always have been fairly optimistic that there would be more money forthcoming. Although common sense told us to look carefully at these services with a view to closing them, we were not in a financial crisis and we let them continue."

District Nursing Officer

The timing of the paediatric ward closure was not conducive to a peaceful development. It was later questioned by the CHC working group set up to consider the permanent closure of the children's ward.

"The working group did not subscribe to the Authority's view that the ward was under-used but stressed that, for years, the number of beds was higher than was necessary. It was suggested that the reduction of beds should have been implemented earlier thus making saving over a longer period of time."

Secretary to the CHC

The closure of the maternity unit at Isebrook emerged as one of the major elements contained in the package of immediate cuts in services proposed by the DGM. Setting aside the closure of the GPMU, the package included a proposal to close the paediatric ward at Isebrook Hospital as well as a reduction in the community service budget and in the nursing establishment at Kettering DGH. The sequence of events leading to the closure of the GPMU was influenced by other elements contained in the financial package and in particular by the proposal to close the paediatric ward.

"We had less opposition to the closure of the maternity unit because the closure of the children's ward focused everybody's attention on that. We did not plan it deliberately. The size of the financial problem meant that we had to close something else as well. If it had been dealt with in isolation, the closure of the maternity unit would have been more difficult but the result would not have been any different."

District General Manager

Given the importance of speed, the initial proposals concerned the temporary as opposed to the permanent closure of both services.

"We were under very heavy pressure to curb our expenditure rapidly. The temporary closure was genuine. It was not a devious way of achieving a permanent closure. We were worried about moving in the unknown by not having this maternity unit available. There were a lot of unanswered questions when we closed. The prospect of reopening the

units and certainly the GPMU was not to be ruled out. We entered into the process with quite a short horizon."

District Nursing Officer

However, the DGM pointed out to all the people concerned that, even with the temporary closure, the permanent closure of these services was still a possibility.

"It is recognised that temporary closures are often seen as the forerunners of permanent closures. Clearly the Authority has to avoid the continued over-spending and in due course it will have to decide if any of the measures are to be permanent. It would be wrong not to recognise this possibility for either of these wards. It is stressed that such a recommendation has not been made and would require full formal consultation."

DGM's letter on the temporary closures

The district's reasoning for advancing the temporary closure of the GPMU was twofold: (1) savings, (2) existing alternative facilities within the District.

The savings in a full year of the closure of the GPMU was estimated in the region of £50,000. This was largely undisputed. The savings were to be realised from voluntary as well as compulsory staff redundancies.

The key element of the District approach to closure was to highlight the alternative proposals should the closure of the GPMU proves unsuccessful.

"Basically we were saying that if we cannot close the maternity unit something else would have to go. There was a distinct possibility of having to close an acute ward as well as a long stay ward. For those there was no alternative provided in the District. The maternity unit was comparatively under-used. We took on trust the working party's conclusion that Isebrook GPMU's workload could be handled in the Kettering main maternity unit though not without creating some difficulties."

District General Manager

Setting aside the search for savings, the District reasoning for closing the paediatric ward was twofold: (1) the relatively low usage of the beds, and (2) the health profile of the children who were using the facility.

The net revenue saving resulting from the closure of the paediatric ward was estimated at £150,000. On average 50% of the staffed beds and 30% of the available beds were occupied. The advice given by the DMO to the DMG was that the unit was supporting a client base that, according to modern ideas, did not need health care.

"One of our principal arguments was that the unit was addressing some of the social as opposed to health care problems. The unit was self perpetuating itself by bringing in children with behavioural problems or emotional disorder who really did not need hospital care per se. It was also largely used for many years to provide relief care for handicapped children who could have gone elsewhere. Indeed there was also a certain percentage of beds used for children with more identifiable but non-acute medical

conditions as well as for the early transfer of children from the main District hospital. However there were enough resources at Kettering General to care for these children."

District Medical Officer

The 12 paediatric beds at Isebrook Hospital were operated as one unit with the 16 beds in the Timpson ward at the DGH. They were shared by three consultant paediatricians who worked in both hospitals. There were also 13 beds for permanent and intermittent relief care of mentally handicapped children in Colton Ward at Rushden Hospital.

Up to the arrival of the Sister in charge of the ward in 1983 much of the ward was used to provide relief care for handicapped children. Since then, the ward was pioneering in the field of the prevention and the treatment of families with abused children and with children suffering from behavioural problems.

The Development of Isebrook GPMU and Paediatric Ward Closure

At the July DHA Board meeting, there was a long debate between the members about whether or not the Authority should close both wards. During the dispute the consultant representative, one of the consultant paediatricians, underlined that the medical staff were in no mood to discuss or co-operate with cuts in patients services. Following extensive discussion of

the issues, it was finally resolved to adopt the steps proposed by the DGM and to go ahead with the temporary closure proposals. This resulted in the resignation of the consultant representative from the DHA Board. He took on the lead in the fight against the Authority's proposal to close the paediatric ward.

"The consultant paediatrician was a strong socialist. He was very much involved in Wellingborough particularly in the community relations care and he felt that we were letting him and the people down."

District Medical Officer

The reasoning of the consultant paediatricians to oppose the closure was essentially twofold. Firstly as a result of the closure, 50% of the paediatric beds in the District would be lost, restricting admission particularly for children suffering from social deprivation and emotional disorder or for abused and handicapped children. Secondly emergency admission would be difficult and children might have to be admitted to adult wards.

Unlike the closure of the paediatric unit, the closure of the GPMU had not come as a shock to the medical staff concerned. There was virtually no support for the unit.

"A very important point was that the obstetricians and the local GPs were not interested in keeping it open. Because of alteration at the DGH maternity building there was enough capacity to expand the

number of obstetric beds to meet the demand to about 1990. The consultant obstetricians saw the closure of Isebrook as an opportunity to centralise all the beds at the DGH. One of the main arguments which saved the Isebrook unit in 1983 was that the commitment of the professionals could be regained to support their local unit. In 1984, we went out to speak to the GPs inquiring why they were not using the Unit as much as they used to. The principal remark which then came out was that the local GPs' surgeries had a substantial number of newcomers who were not particularly interested in practicing midwifery. The word closure was written on the wall for everybody to read."

Director of Midwifery Services

The previous rationalisations of the GPMU and the deferred implementation of its closure paved the way for an uncontested implementation of the proposal. By the time the DHA faced a critical resource crisis the potential opposition groups were well aware of the District financial problem. It was widely recognised that cutbacks would have to be made, and that closure was a probability. The GPs were already resigned to seeing the facility disappear.

"They reduced the number of beds in the maternity unit twice. The closure began to happen a few years beforehand. By 1985 the opinion of the professionals had already changed and we were then ready to let it go. In any case we felt that nothing could be done to save it from the axe. The inevitability came into it."

GP Representative

At the same time, the interest of the local GPs in practicing obstetrics was also diminishing. The

nursing and midwifery staff, however, were not ready to accept the closure without contesting it.

"The actual unit staff itself was very disappointed. They were quite vociferous initially but it was not maintained. Side by side with the opponents to the closure of the paediatric ward, they lobbied the public by having a campaign in the town centre collecting signatures against the closures. They lobbied the health authority members, the council, the MP, but at the end of the day all the support went to save the children's ward and they did not have the CHC backing. They were resentful."

Director of Midwifery Services

With the exception of the closure of the Corby GPMU in 1978, there was no history of confrontation between the DHA and the CHC. Initially CHC opposed all the proposals included in the DHA package of cutbacks. The CHC reasons for opposing the District proposals were twofold: (1) the origin of the District financial difficulties, and (2) the relative contribution of Isebrook Hospital to the accumulated overspending of the District.

According to the CHC members, the District financial problem was not solely the result of a lack of financial control by the District Senior Officers. It was mainly due to a lack of funding from the RHA to provide for the increasing demands upon the Services. Therefore rather than closing services the District ought to press the RHA for more financial resources.

Besides, the package of cuts in services was essentially striking Isebrook Hospital. However it was at the DGH that the over-spending was really taking place.

In spite of the Council decision to oppose the whole District financial package, the Chairman of the CHC, as well as her Secretary, were in broad agreement with the proposal to close the GPMU.

"We tried to look at the proposals logically. The case of the maternity unit was much easier to deal with than the case of the childrens' ward because we had the expertise readily available. Our Chairman is a midwife. My wife is a midwife as well. My own experience as an hospital administrator was most helpful in this particular issue since I have run a maternity unit. The case for closing the GPMU was quite a strong one. We knew that no one could alter the fact that the unit was under-used. It was so uneconomical. We had no solid base on which to mount an objective opposition. We had only one representation from the GPs but after discussion they agreed that their interest was too late. The main opposition came from the staff who were fighting to keep their jobs."

Secretary to the CHC

There was virtually no opposition to the closure of the GPMU. The only exception was the nursing and the midwifery staff who were threatened with redundancy. They were unable to convince the public, and the CHC in particular, that their motivation was legitimate.

Ultimately the CHC acute and midwifery service committee recommended to the Council not to oppose the

closure of the maternity unit. The professional background of the CHC Chairman in midwifery made her arguments all the more convincing and played a critical part in the response to the proposal.

"The CHC acute service committee felt that home confinement as opposed to the GPMU was the alternative to the consultant obstetric ward. The CHC Chairman who was a midwife had strong views about it. The other lay members of the CHC had limited knowledge regarding maternity services and it was difficult to override the influence that the Chairman had. The fact that the Chairman of the CHC declared her position fairly soon did not help our cause at all. We did not get the County Council support either. One of the most vocal councillors was also a DHA member. He was quoted in the local press stating that the unit should be closed. By the time the proposal went back to the Council for decision it was already obvious that the maternity unit had gone leaving only the children's ward to fight for."

Midwifery Staff Representative

The Chairman and the Secretary to the CHC were also aware that the children's ward was used by some children who did not necessarily need hospital care.

"We knew, unofficially, that because the paediatricians needed to keep the occupancy figures up, the children's ward was being used by some parents of handicapped children almost like a baby sitting circle. There was no reason to fight to keep this going. However there was a small group of children for whom a facility ought to be kept open. The problem as we saw it became to find a way to retain that particular part of the service for these children."

Secretary to the CHC

In fact, the figures concerning the children looked after on the ward showed children admitted for medical reasons representing 45% of the bed days used while handicapped children represented 25% of them. The remaining 30% was used by abused children or children with difficult behaviour. The latter group was at the core of the controversy.

There was considerable publicity in the media and public reaction. Letters from parents of children cared for in the paediatric ward as well as from users of the maternity unit began to be received by the Authority. The prevailing attitude was concern about the services in Wellingborough, concern about the future of Isebrook Hospital, and concern about what was happening to the NHS in general, rather than the particular advantages and disadvantages of the closure of the maternity unit.

A "Save Isebrook Campaign" was launched by two mothers of handicapped children who regularly used the paediatric ward. The control of the campaign committee was, however, taken over by the local branch of the Labour Party.

"We got a bit worried at one stage because it was getting too political. We very much felt that we were being used by the people from the Labour Party who turned our campaign into a political issue. The actual issue of the children's ward was overshadowed by the

political arguments such as the under-funding of the NHS and the like. It got out of hand in that sense."

Joint Secretary Save Isebrook Campaign

The Trade Unions officially registered their opposition to the closures urging the Authority to clarify the position of the staff if the plans were to go ahead. However they failed to mobilise their membership and to undertake any collective action against the District proposals. As an alternative, the individual Unions officers joined and supported the Save Isebrook Campaign.

"The history of Trade Union militancy in Kettering is minimal. We tend to have something of a "shy mentality". It is extremely difficult to get the Trade Unions to work together. We used the district grievance procedure to try to register an objection particularly to the closure of the children's ward but it appeared inappropriate. The Trade Unions had more input in the fight against the District's proposals via the individual unit officers taking membership with SIC."

JTUC Secretary

The local Conservative MP, Mr Peter Fry, proffered his support to opponents of the closures. The District was a marginal constituency held by the Government. The MP had already put his efforts into other saving campaigns in the constituency such as the closure of British Leylands Foundry and the closure of General Motors Factory. He instigated a meeting

between the Minister of Health, Mr Kenneth Clarke, and a delegation of 3 parents and 3 members of the staff concerned by either one or the other closures. The meeting was held on 30 July 1985.

A protest march was led through the town by the local MP, the Deputy Mayor, and the Chairman of the Save Campaign. A petition was signed by approximately 30,000 people. The possibility of legal action was considered by the SIC and by the Borough Council. The protestors suggested that the Authority took the decision to close the GPMU and the Children's Ward based on out-dated figures and new figures showing increasing level of activity were sent to the Minister of Health.

Within two weeks of its meeting with the delegation, the Minister of Health requested the DHA to issue a clear statement about the alternative facilities before closing any services. He also requested the Authority to specify clearly whether the closures were to be permanent or temporary.

"Some of our planning was not as good as it should have been. When the proposal was first mooted the medical advice we were given was that the unit was used by children who did not need hospital care. This advice was not entirely well founded. There were in fact a small number of children for whom the unit was some sort of a life line. The opponents were able to show to the Minister

that we were unable to be very precise about whether the alternative facilities were satisfactory or not."

District General Manager

The lack of detailed up-to-date knowledge of the services provided to the individual child by the paediatric ward justified the veto of the Minister on the closure. As a result, the initiative was given to the opponents to the closures.

"It became apparent that we would not get the Minister's agreement to a closure. The most influential opponents were the consultants and the CHC. Until the anxiety being expressed by those two powerful groups could be resolved the likelihood of getting the Minister's agreement for the closure of the children's ward was very slim. That did not apply to the same extent to the GPMU because the alternative provision was clearly accounted for."

District General Manager

The CHC Chairman and her Secretary offered a reluctant acceptance of a solution to address the District financial problems and refused to antagonise further the controversy over the children's ward.

"We knew we had them over a barrel. However we did not want to keep the whole children's ward open for the sake of it. The District needed savings and they were seriously threatening to close either a surgical or a geriatric ward. We had hostility from the Save Campaign group because we were not opposing the closure of the GPMU and because we did not want an unconditional withdrawal of the paediatrics' closure proposal. We wanted to save the service not the ward itself. That was extremely important. We had to fight to get the people to understand

that. The parents understood but the politicians did not. The operational details such as where and how many beds were all negotiable. We managed to get in between the Authority, the Save Campaign, and the parents. We acted as a mediator."

Secretary to the CHC

At the request of the DGM, a list of names of children using the ward was produced by the Sister and an inventory of the alternative facilities was made. A community nurse visited the parents to find out what they needed and to see whether the alternative facilities would be acceptable. The opposition group and the paediatricians were unwilling to accept the study of alternative facilities and they undertook their own assessment of alternatives. The paediatricians condemned the alternative facilities offered on the grounds that none of the people involved in consulting the parents or in developing the alternative were professionally qualified.

"You may well have been strongly advised by medical and nursing representatives, on the Management Team, about what is best for the treatment of children. None of these are paediatricians or paediatric nurses and their advice runs counter to that of specialists in child health and illness ... Children's services within the District are being cut and they are being managed by people with no knowledge at all of the needs of children."

Letter from the Consultant Paediatricians

Meanwhile the DGM pressed on with the remainder of the financial package and with the temporary closure of

the GPMU in particular. The temporary closure of the GPMU was effected on 30 September 1985. Three midwives and one auxilliary nurse were transferred from Isebrook to the DGH. Eight midwives were made redundant.

The Chairman of the Authority informed the Minister of the temporary closure of the GPMU pointing out that arrangements were made for all mothers to be cared for in the main maternity unit at the DGH. In his reply, the Minister pressed the District to decide as soon as possible the long term future of both wards. Further discussion between the Chairman and the DGM concluded that the Authority was then ready to consider the permanent closure of the maternity unit. However the DGM recommended that the Authority should wait until alternative arrangements had been made with the parents to consider the permanent closure of the paediatric ward.

A paper prepared by the District Treasurer and showing the financial outlook for the District was circulated widely to the staff, the advisory groups, and the consultative committees. The aim was to stimulate discussion about what had to be done to put the situation right. At best the outlook predicted an over-spending of £463, 000 while the worst prediction suggested an over-spending of £968,000.

On 8th October, the Chairman of the Authority wrote to the Minister giving him details on the offers which had been made to the parents. Most of them were reported to be happy to use the alternative resources offered. However one of the mothers of a handicapped child whose name was on the list among the parents happy to use alternative resources stated publicly that she had not been offered officially any alternative for her child. The fact was reported to the Minister by the MP as undermining the credibility of the list.

The consultant paediatricians indicated to the Minister that the proposals were not suitable to meet the needs of their patients. However they put forward their own counter-proposal recommending a further reduction of 4 to 6 beds in the children's ward.

"The paediatricians realised that they would lose the service altogether unless they did re-think what they were talking about. They started talking about reducing the number of beds. That was the first step toward a possible compromise."

Secretary to the CHC

The CHC pointed out that a full consultation procedure should be implemented.

The Conclusion of the Isebrook's Closure Proposals

At its public meeting held on 26th November 1985, the Authority accepted the Chairman's recommendation to begin the statutory consultation on the permanent

closure of the children's ward. The Chairman's reasoning for changing his approach was twofold. Firstly, the delay in implementing the temporary closures jeopardized any significant saving in the financial year. Secondly, the Authority had then a clearer financial picture which showed significant over-spending for another two years.

A consultative document was issued on January 9, 1986. The District's reasoning for advancing the permanent closure of the paediatric ward was twofold: (1) savings, and (2) opportunity to create an integrated Children's department at the DGH.

"The Authority is taking this step not only because it feels this is one way of reducing its expenditure, but because it thinks that there are advantages in developing paediatric care on one site at KGH ... The Authority's Strategic plan set out the overall philosophy that children should be nursed together by trained paediatric nurses not in separate specialty wards ... The Authority therefore proposes to consolidate the care for children in the District and by making changes that fit into previously declared national, regional, and local policies, set the foundations for a greatly improved and co-ordinated service for future years."

Consultation Document

A public meeting to be held on February 25, 1986 was called by the Save Isebrook Campaign. The Chairman of the Authority declined the invitation to participate. The strength of the parents' opposition to the closure was diminishing.

"At that stage basically everybody was satisfied with the alternative proposals. It boiled down to the two of us. We were told that our handicapped children did not need hospital care. The meetings were attended by only a handful of people."

Joint Secretary Save Isebrook Campaign

On February 14, 1986, the DHA published a consultation document on its proposal to make permanent the temporary closure of the GPMU. The District's reasoning was twofold: (1) there was enough capacity at Kettering DGH to meet the demand, and (2) the closure would allow the building to be re-used for geriatric patients who were currently cared for in old victorian accommodation.

Whilst not deliberate, the permanent closure of the GPMU was more readily acceptable when finally proposed because of the temporary closure. At the end of the consultation period on closure of the Isebrook GPMU a total of 15 replies were received. Of them only two opposed the permanent closure: the Kettering Borough Council and the Save Isebrook Campaign. In short, the Councillors maintained plainly their former position. The SIC published a nine page document criticising the Authority's proposal on many grounds. Primarily the Campaign committee blamed the Authority for "putting cash before caring", for "having little thought spared for the future", and for "increasing

workload and stress on staff as well as on pregnant mothers". Doubts were expressed on statistics, savings, and performance figures.

All the advisory committees supported the closure. On September 25, 1986, a motion not to oppose the permanent closure of the Isebrook GPMU was passed by the CHC.

Meanwhile, in April, the CHC set up a working group to draft a recommendation on the closure of the children's ward. A meeting between members and representatives of the Authority and the CHC's working party was held on May 8, 1986. At the meeting the transfer of six beds from Isebrook to the DGH was suggested by one of the CHC members.

"One of our ENT consultants left the District. We were concentrating the ENT function into the Nightingale ward. This left enough room for the transfer of the six beds creating a self-contained unit for the treatment of children with special problems."

Administration and Planning Officer

A joint DHA/CHC working group approach was proposed by the DGM. Nevertheless because an agreement could not be reached before the end of the formal consultation period, the CHC working group recommended that the CHC should oppose the closure. The recommendation was adopted by the CHC on May 22, 1986.

Meanwhile the Authority was investigating the possibility of transferring the beds from Isebrook to the DGH. Following a second meeting with the CHC and after having gained the support of the consultant paediatricians for the proposal, the DGM recommended that 6 children's beds should be transferred from Isebrook to Kettering DGH.

"The Authority's decision was mainly based on the fact that it was cheaper to run the children's beds at the DGH. We estimated the saving at approximately £65,000 in a full year. The beds would be used more effectively as part of an integrated paediatric department in the DGH rather than kept in isolation in Wellingborough. We also felt that the solution was creating a base for the future development of the paediatric service in the District. Finally the compromise was acceptable by the CHC as well as by the consultant paediatricians."

District General Manager

On July 24, the CHC withdrew its opposition to the children's ward closure. The beds were transferred from Isebrook Hospital to Kettering DGH in April 1987.

"Despite all the trauma we went through the closure of the children's ward has been very successful. In the face of the opposition we worked out an alternative which was acceptable to the objectors because they were involved in working it out. Perhaps you need to leave yourself some space to work out a proposal. Allowing the opposition to voice their anxieties and then bringing them in is perhaps more constructive. We did not do it deliberately but it worked that way. The original proposal was modified by the process of consultation."

District General Manager

Concluding Discussion

The Kettering DHA proposal to close the Isebrook GPMU was presented concurrently with a similar proposal to close the hospital paediatric ward. From the point of view of the DHA, the closure of the GPMU proved highly successful whereas the paediatric ward resulted in a compromise solution. Why was the proposal to close the GPMU implemented so successfully when the previous proposals were not, and when the DHA's concurrent intention to close the paediatric ward was frustrated?

Continuity of Key People Providing Leadership

The evidence indicates that the key factors in these closures revolved primarily around a politically aware DGM who began establishing the legitimacy of the proposals a number of years before they became formal issues. There is little evidence that the implementation of general management in Kettering had a significant influence on the process and outcome of the proposals. The case-study points to the influence of the continuance at top management level and to the managerial skills of the DGM in connecting up logically admissible solutions to legitimate problems. The failure to close the paediatric ward illustrates the crucial part of timing in this process. As Stewart

(1989) pointed out:

"Some times are better than others for getting changes accepted because people are more open to accepting the need for change. Part of the art of managing change is recognising when something has happened that makes people more willing to accept change" (p.22)

The Approach to Implementation

The managerial thinking and action conform to the Organisational Development Perspective of implementation which emphasizes consultation and participation in the decision-making process as a key factor to secure successful implementation (see Chapter two). The DGM demonstrated a definite will and a strong lead for some sort of action to be undertaken to correct the district financial situation. There was, however, a genuine opportunity for those being consulted to produce alternative solutions to the financial problem. The type of leadership which emerged was not unlike the principle of "tight and loose management" which, according to Korman and Glennerster (1990), was used by the South East RHA to speed up the closure of the Darneth Park Hospital in the 1980s (see Chapter Three). Such a style of leadership was consistent with the tradition of the district.

Since its inception in 1982, the DHA had sought to explain exactly its precarious financial position,

particularly to the CHC, and to justify its proposals while deferring closures and exchanging views with the potential influencers about what had to be done to rectify the situation. As Hardy (1985) pointed out:

"The explanation of the reasons behind a closure is an important element in the management of meaning. A decision which is justified on the basis of acceptable criteria is itself acceptable ... Reasons confer legitimacy, not because they are, in any objective sense, right, but because they are deemed legitimate by the groups in question." p.111).

By floating an extensive list of potential proposals for closure, as well as details about the District financial difficulties, the District Officers contributed to creating some of the favourable local conditions for implementation. In this case, the actions of the officers reduced the motivation to resist implementation. By the time the DHA faced a critical resource crisis, the potential opposition groups and the CHC, in particular, were already convinced that cutbacks would have to be made and that closures were a probability. The Chairman and the Secretary to the CHC were persuaded that keeping the GPMU and the whole paediatric ward in Isebrook would have negative consequences particularly on the priority group services.

The Will, Skills and Power of the Opposition

The local context afforded the officers some advantages which complemented their actions. For instance, one of the key factors in the successful implementation of the proposal was the lack of clinical support for the GPMU. The Officers were fortunate that the consultants' support for a locally based service at Isebrook hospital vanished completely as a result of the alteration made to the DGH building. The CHC's awareness of the need for savings, combined with the lack of clinical support for the retention of the Isebrook GPMU, were particularly important factors which eased the implementation of the closure proposal. Other favourable features of the local context include: the lack of emotional appeal of the hospital in the community, the central location of the alternative facility, and the history of relatively good relations between the CHC and the DHA.

The implementation of the proposal to close the paediatric ward revealed much more controversy than the closure of the GPMU, primarily because medical opinion was against it. The evidence suggests that the presence of a paediatrician with the will and the political skill to champion the opposition was a key factor in the failure of the district to close the

paediatric ward entirely. As Hardy (1986) pointed out,

"Medical opinion is obviously influential in decisions in health service, particularly when services are being curtailed: the use of profit and loss criteria are not usually perceived as legitimate reasons for the withdrawal of services; medical opposition can easily override any financial arguments in the eyes of the public, employees and unions, the AHA, and often the government" (p.20)

Clearly the national political context enabled the opponents to resist implementation (see Chapter five). The District was in a marginal constituency and, at the time, increased national attention was being paid to the issue of child abuse. These factors raised the political profile of the proposals, and attracted the local MP and the Minister's interest comparatively early in the proceedings. Because the District's proposal was based on an inaccurate premise the opponents were able to de-legitimise the closure and to secure the Minister's support for their cause. This tends to substantiate the Rational Planning Perspective of implementation (see Chapter two) stressing the soundness of the planning premises as a key factor in implementation.

The opponents to the closure of the paediatric ward used the Minister's support to prevent the temporary closure and to force a formal consultation over the closure proposal. Their power, however, was

limited because they did not have the absolute support from CHC staff in critical posts, who believed that the district was really facing a serious resource crisis. In this case the mediation of the CHC was an important aid to implementation. The CHC counter-proposal offered a fortuitous opportunity to reach a local agreement which the DGM did not fail to use involving further the CHC in working it out. The transfer of the paediatric ward to Kettering DGH resulted from the same sort of opportunism which brought it to Isebrook Hospital in the first place.

Summary and Conclusions

In summary, this case study shows how managerial action can shape context and events. The fluid and emergent nature of strategy is well illustrated by the case study. The strategy of the DHA can best be described as ad hoc and emergent. Although the District Officers did not have a predetermined, detailed strategy for closure, the decisions and actions led towards the closure of the Units.

The DHA officers had already set some of the conditions for implementation by reducing the number of beds in the maternity unit and by flagging up the closure proposal well in advance. They also made sure that the public and the staff were well aware of the

seriousness of the situation by widely circulating details of the District financial outlook, in order to stimulate discussion about what had to be done to put the situation right. The implication that one of the major roles of managerial action in implementing change is to alter context (Pettigrew et al, 1989) is clearly supported in this case-study. The evidence features the DGM managerial skill in creating an overall climate for change to occur as a key factor in the successful implementation.

A further important substantive finding is that consultation can serve a very useful purpose, thereby improving the proposal being implemented.

CHAPTER TEN

Implementing The Proposals

In presenting an analysis of the implementation process described in the last four chapters, this chapter begins with an investigation of the districts' responses to central government policy over the period from 1970 to 1989. The second section then examines the key features of implementing the closure proposals among the districts investigated to see if there are any patterns in those processes. Later in the chapter, the theoretical approaches to implementation posited in chapter two are reviewed in the light of the empirical evidence of the research. Finally, the chapter presents a summary and conclusion of this dissertation.

National Policy and Local Strategies

This research provided an opportunity to examine the implementation of change in the provision of inpatient maternity beds in four health districts since the current central policy was formulated in 1970 (see Chapter five). The districts had much in common. All four were neighbouring health districts belonging to the same RHA, they were operating during the same period, sharing a broadly similar outer environment, facing the same changing policy context, and all were under similar pressure from higher tiers to review the

structure of services provided, especially to close their peripheral GPMUs. On these grounds, and in the light of the classical approach that still dominates both the literature and practice of implementation, one could expect the districts to adopt very similar maternity bed provision strategies in response to the central government policy.

Following the approach taken by Pettigrew (1977, 1985), Mintzberg (1978) and Mintzberg and Waters (1985), strategies can be viewed as "a pattern in the stream of decisions" (Mintzberg, 1978, p. 24). The key local health authorities' decision streams relating to inpatient maternity facilities can be grouped into three categories: (1) services offered, including opening, transfer, temporary closure, and permanent closure of obstetric wards and maternity units; (2) resources and, particularly, increase and reduction in the number of beds; and (3) the management of closure, including the formal consultation on permanent closure of facilities in the district.

Figure 10-0 presents a summary of the decision streams from 1970 to 1989 with respect to maternity bed provision in the four health districts investigated.

Figure 10-0

Diary of Change in GP Maternity Bed Provision
in Wycombe, Oxfordshire, Milton Keynes, and
Kettering health districts
1970 - 1989

DISTRICT	Year																			
GPMUS	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89
WYCOMBE																				
Amersham							or							*t		or	**	t	
Stone				*			+													
Shruberry							o							+						
>Shruberry Ward							DGH							o						
OXFORDSHIRE																				
							DGH													
>Churchill							+													
>John Radcliffe							or													
>Horton																				
Moreton					x															
Bicester							r			+										
Brackley														*		+				
Abingdon			r			r		*	r		**					***		****	+	
Chipping											r									
Wantage				r																
Wallingford				o			r				r									
St George					+															
MILTON KEYNES																				
Bletchley													*							
Westbury													**							
>General																				
KETTERING																				
Corby							*		+											
Isebrook							r				*	r				t	***			

Key to Symbols per Category of Decisions

(1) Services Offered

o : Unit Opening
+ : Unit Closure
t : Temporary closure
x : Out/Boundary change
DGH: Opening of DGH wards

(2) The Management of Closure

* : First Formal Closure Proposal
** : Second Formal Closure Proposal
*** : Third Formal Closure Proposal
****: Forth Formal Closure Proposal

(3) Resources: ^ : Opening of beds, r : Closure of beds

The Policy Implementation Processes

An analysis of Figure 10-0 reveals a number of patterns or periods in the decisions relating to the provision of inpatient maternity beds of each district investigated.

Figure 10-0 shows three periods in the policy implementation process of Wycombe health district. The first of these periods came to an end in 1976 when the new Wycombe DGH opened its obstetric ward. Although a formal proposal to close one of the GPMU was issued during the first period, the level of resources did not change. The second period began in 1976 with the transfer of all consultant obstetrician beds to the new Wycombe DGH obstetric ward. This period is characterised by the opening, in breach of the national policy, of two peripheral GPMUs in the facilities vacated by the consultant obstetricians. The final period began in 1983 with the opening of an integrated GPMU in the Wycombe DGH bringing about the centralisation of all GP maternity beds in 1987 following the "temporary" closure of the Amersham GPMU. Table 10-0 summarises the pace and rate of change in Wycombe.

An examination of the decisions and actions in the Oxfordshire health district also reveals two major periods, the first ending in 1979. During this period the district spared none of its peripheral GPMUs from

rationalisation, but retained all of them. The second period began in 1980 when the pattern of decision streams changed. In contrast with the preceding period, there was no emphasis on bed reduction during that period and permanent closures of facilities were achieved. These periods are illustrated in Table 10-1.

One of the difficulties in trying to identify the patterns in the decisions and actions in Milton Keynes health district is that before 1982 the services were administered by two neighbouring districts. Three periods, however, seem to emerge from Figure 10-0.

Services remained unchanged during the first period after a number of beds were added in Bletchley in 1972. During the second, short, period between 1982 and 1984, the district maternity bed provision was radically transformed and the centralisation of all GP maternity beds in the district was achieved. During the third period, no further changes were implemented. Table 10-2 summarises the rate and pace of change in Milton Keynes.

Figure 10-0 shows three periods in the Kettering health district's maternity decisions. Until 1976 the services remained unchanged. One of the district GPMUs was then closed and the number of GP maternity beds available was reduced further on two occasions: first in 1976 and again in 1983. In the meantime, the number

of obstetric beds available in the DGH was progressively increased. The third period began in 1985 with the temporary closure of the Isebrook GPMU and resulted ultimately in its permanent closure in 1986. From then onwards there was only one element of maternity bed provision in the district: consultant obstetric wards in Kettering DGH (see Table 10-3).

Table 10-0

The Rate and Pace of Change in the
Provision of Inpatient Maternity Beds
Wycombe Health District
1970 - 1989

Year																			
70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89
First Period					Second Period					Third Period									
Continuity					Revolutionary Change and Then Continuity					Evolutionary Change									
					Centralisation of All Consultant Obstetric Beds And Increase In Peripheral GPMUs Capacity Through Change of Use of The Old Consultant Obstetric Wards					Capacity Reduction Through Closure of All Peripheral GPMUs									

Table 10-1

The Rate and Pace of Change in the
Provision of Inpatient Maternity Beds
Oxfordshire Health District
1970 - 1989

Year																			
70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89
First Period										Second Period									
Evolutionary Change										Evolutionary Change									
Excess Capacity Reduction Initiatives										Voluntary Closure and Conversion of GP Maternity Beds									

Table 10-2

The Rate and Pace of Change in the
Provision of Inpatient Maternity Beds

Milton Keynes Health District

1970 - 1989

Year																			
70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89
First Period										Second Period					Third Period				
Continuity										Revolutionary Change					Continuity				
										Centralisation of All Peripheral Units									

Table 10-3

The Pace and Rate of Change in
Inpatient Maternity Bed Provision

Kettering Health District

1970 - 1989

Year																			
70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89
First Period										Second Period					Third Period				
Continuity										Evolutionary Change					Continuity				
										Increasing Consultant Obstetric Capacity And Then Reducing GP Maternity Provision									

The Districts' Responses to the Central Policy

The first point to be made concerns the variability of local strategies. Again, caution must be taken in drawing general conclusions from the small sample of districts which may not be typical. The evidence clearly indicates that compliance with the national policy has not been homogeneous nor automatically secured across districts. This suggests that the local health authorities have had significant potential influence and discretion for autonomous action over the character, volume, or distribution of the local services they have chosen to provide. The best example lending weight to this point is, perhaps, provided by the Oxfordshire health authority where the officers, in collusion with the local GPs and the Regional Medical Officer, have decided to develop the district small community hospitals and, as a result, preserve their GPMUs.

The discretion of the local health authorities in implementing policy change has now been established from a whole series of research studies and writing on the relation between the centre and the periphery in the NHS (Mackenzie, 1979; Hunter, 1979, 1980, 1983; Haywood and Alaszewski, 1980; Ham, 1981; Gray and Hunter, 1983; Allen, 1985; Tomlinson, 1988; Gunn, 1989). The clear message of these studies is that in areas of agreement both the DHSS and the health

authorities move quickly together whilst in areas of disagreement, and particularly on the issue relating to medical priorities, the power of the local authorities will generally prevail. Having reviewed the literature on the relationship between the DHSS and the health authorities, Allen (1985) concluded:

"It seems that health authorities are anything but the mere creatures of the Secretary of State. They have considerable independence and vitality which is due not only to the members and officers of the authorities, but also to the power of the medical profession ... In terms of finance, the centre is most effective. The DHSS through setting resource allocation and wage and price levels centrally does have considerable power. In terms of setting medical policy, the centre is less effective. It is here there is greatest conflict. The centre can lead health authorities where they want to go. If the periphery does not want to go, then it will prevaricate" (p.60).

The evidence reported in the present research indicates that although the DHSS policy was more than merely symbolic, little direct attempt was made by central government to induce compliance and impose its will on the district investigated. DHSS policy was permissive rather than mandatory. In Hunter's (1979, 1980) words, the DHSS policy was primarily "contextuating rather than prescriptive" (p.45):

"Outside the field of major capital expenditures, central influence is largely geared to dealing with classes of local issues rather than with specific local issues. In short, most central control is contextuating rather than prescriptive - the

centre is primarily concerned with setting contexts for local operations through formulating generic policy positions" (Hunter, 1979, p.45).

Even at the district level, the closure of peripheral GPMUs had a relatively low visibility. This was particularly true in Oxfordshire where the officers were too busy implementing major change in acute and priority services to raise the issue of GPMUs and spend managerial time and energy on a potential controversy with the medical staff involved. Perhaps the influence and discretion for autonomous action over the local services is not so evident in larger, more central change, such as the implementation of "Working for Patients". Theoretically what this means is that local discretion might vary according to change content investigated. However, much of the analysis of organisational relations in policy implementation in the NHS as well as in other public services have been , so far, "policy-free" (Fudge and Barrett, 1981, p.271) in the sense of disregarding the specific subject matter and intention of policy as a factor affecting the process and outcome of implementation.

The preceding discussion has not sought to argue that environmental forces and top-down pressures for change were totally ineffective in securing change at local level. Further analysis of the diary of change in maternity bed provision (Figure 10-0) across the

districts reveals two periods when, although change was not always successfully implemented, the issue was concurrently on the active change agenda of all districts investigated : 1976 to 1978 and 1982 to 1986. In reviewing the evidence it is clear, therefore, that from the DHSS point of view these periods can be sensibly labelled as "periods of high levels of change activity" (Pettigrew, 1985, p.446).

Recalling the evidence of Chapter five, each of these periods can be associated with changes in the UK economic fortunes and their effects upon public spending in Britain. Both periods were preceded by oil shocks followed by rapidly increasing inflation (Smith, 1984) and both periods took place against backgrounds of recovery from recessions (Whittington, 1989). More significant, perhaps, is the fact that both periods featured substantial cuts in public expenditure so that pressure for closure became more tangible (Bramley and Stewart, 1981; Small, 1989). Finally the pattern of change between low and high level of innovation activity matches the ideological shifts in emphasis between permissive local discretion at one extreme and firm central control at the other in the evolution of DHSS relations with the local health authorities during the period covered by the present research (Hunter, 1983; Allen, 1985).

Thus, the overall momentum for implementation seems to have been influenced by environmental forces and top-down policy pressure. But, the trigger effect of those broad forces and pressures were, in themselves, insufficient to create the will for implementation at district level. The evidence shows that, in addition, specific local disturbances were also required (Table 10-4). The districts that closed their GPMUs over the period investigated did so primarily in order to deal with specific local problems and to seize local opportunities.

The closure of the peripheral GPMUs investigated was essentially reactive as opposed to proactive, meaning that the district officers attempted to deal with the issue after a local occurrence requiring action or a response which could not be avoided. Of all the proposals issued for formal consultation over the period of the research only one was essentially proactive: the unsuccessful proposal to close the Amersham GPMU in Wycombe. The overall pattern was for implementation to be precipitated by local events bringing a renewed consciousness of the national policy which then was mobilised by the officers to enhance legitimacy for the closure. This was particularly true in the case of the closure of the Bletchley GPMU and

Westbury Maternity Home by the Milton Keynes DHA (see Chapter eight).

Table 10-4

**The Specific Triggers for Consultation
on Closure Proposals in the
Districts Investigated**

DISTRICT	Year	Trigger	Type
GPMUs			
WYCOMBE			
Stone	1974	Council road work	Opportunity
Shruberry	1983	Opening of DGH wards	Opportunity
Amersham	1983 1986	DHA Operational Plan Space for Developing a Readaptation Unit	Opportunity Problem
OXFORDSHIRE			
Bicester	1980	GPs' decision to stop providing the services	Opportunity
Brackley	1983	Retirement of Senior Nurse	Opportunity
Abingdon	1978 1981 1986 1988	Review of services Review of services Financial Crisis Capital Opportunity Relocation PRU	Problem Problem Problem Opportunity
MILTON KEYNES			
Bletchley	1982	Commissioning DGH	Problem
Westbury	1978 1982	Boundary changes Up-grading work	Opportunity Problem
KETTERING			
Corby	1976	Opening DGH wards	Opportunity
Isebrook	1986	Financial Crisis	Problem

Thus, it is by no means clear that the maternity bed provision strategies of the districts investigated were primarily guided by the shining star of the current national policy. The conventional wisdom that implementation is an automatic follow-on from policy decisions is challenged by the evidence reported. Rather, the present research supports the view that the local health authorities have considerable power of discretion in implementing DHSS policy.

Policy and Strategies: Concluding Summary

The first section of this chapter has investigated the districts' responses to central government policy over the period from 1970 to 1989. The main themes of the preceding discussion can be summarised as a set of simple statements:

- * Compliance with national policy has been neither homogeneous nor automatic. This has been attributed to the power of discretion of the districts in implementing policy change, as well as to the "contextuating rather than prescriptive" (Hunter, 1979) status of the policy itself.
- * Two periods of "high level of change activity" (Pettigrew, 1985) in the districts' provision of in-patient maternity beds have been found: (1) 1976 to 1978; and (2) 1982 to 1986. These periods were linked to UK economic downturns and with their associated effects on public expenditure, as well as on the centre-periphery relations in the NHS.

- * Environmental forces and top-down policy pressure for change were, however, insufficient to create the will for implementation at local district level. A mixture of such broad forces, and pressures, and specific local problems and opportunities was necessary to trigger off the implementation process.
- * The overall pattern was for implementation to be precipitated by local problems and opportunities followed by a renewed consciousness of the national policy which was then mobilised to enhance the legitimacy of the closure proposals.

The depth, rate and pace of implementation clearly differ across the districts investigated. The next section starts by reviewing the elements of the literature on rate and pace of change before revealing the common patterns in the closure processes.

The Rate and Pace of Change Across Districts

The first point to be made, as stated earlier in this chapter, concerns the variability of local strategies. Following on from this, the second important point to be made concerns the variability in the processes of implementation across the districts investigated. The analysis indicates that apparently similar districts can adopt quite different service strategies, rate and pace of change at micro-implementation level: Wycombe increased significantly its maternity bed provision in peripheral GPMUs before undertaking to close them all following the 1982

Reorganisation. Oxfordshire held onto virtually all its peripheral maternity units concentrating on excess capacity reduction initiatives, staffing innovation, and conversion. Milton Keynes radically transformed its maternity bed provision by centralising all peripheral beds at the opening of its DGH in 1984. Kettering adopted a more piecemeal and gradual approach alternatively increasing its consultant obstetric beds and then phasing out its peripheral maternity beds. Clearly, the rate and pace of change, if not the final policy goal, varied across apparently similar districts.

This theme of variability in depth, rate and pace of policy implementation across districts was also found in the CCSC's research at the Warwick Business School. According to Pettigrew et al (forthcoming) there is neither a strong social science tradition nor a great welter of empirical studies seeking to describe and explain differences in the rate, pace, and depth of change. They present Kanter (1983) and the works carried on at the CCSC (Pettigrew and Henry, 1991; Pettigrew and Whipp, 1991) as important contributors to the debate on depth, pace, and rate of change in varying localities.

Kanter (1983) argued that some features of structure and culture are broadly facilitative or

inhibitative to the processes of creating innovative change in organisation. She distinguished between, on the one hand, integrative structures and cultures which are supportive of change processes and, on the other hand, segmentalist structures and cultures which encourage an antichange style of thinking and problem-solving. The latter feature compartmentalised problems, control and ownership of ideas, secrecy, bureaucratic hierarchy and rules as well as finely divided structure with clear levels, status, and functions. In contrast, the integrative structures and cultures feature holistic problem solving, team work, mechanisms for idea generation and circulation, clear sense of direction, and a drive for leverage and experimentation. The stability of key actors championing change and the processes of bargaining and negotiation which can raise support and increase the legitimacy for change are found to be the complementary conditions for the delivery of innovation.

Kanter's (1983) distinction between integrative and segmentalist structures and culture is, even in her own words, directly akin to Burns and Stalker (1961) dichotomy of organic and mechanistic organisations. In the present research, the contrast in pace and fate of implementation, particularly between the roughly integrative structure and culture in Kettering, and the

initial segmentalist structure and culture in Wycombe, tends to support Kanter's (1983) thesis. The contrast between the failure of the first proposal and the success of the second proposal to close the Amersham GPMU in Wycombe health district can also be interpreted in terms of move from a segmentalist to an integrative structure and culture, continuity of key actors, and skills of the champions for change ideas in managing the processes so as to raise support and increase the legitimacy for change.

Pettigrew and Hendry (1991) investigated the motors and barriers to training and human resource change in organisations. The overall pattern is for pressure in the outer context of the firms, and for competitive pressures in particular, to increase leading to business strategy changes which in turn highlight human resource deficiencies and the consequent human resource change. However, the single effect of business strategy changes in itself was found to be insufficient to secure sustained training and human resource change. Three other complementary factors were also found necessary: (1) the external/internal labour market; (2) an internal champion for human resources as well as the availability of the appropriate systems, philosophies, and management organisations; and (3) external human

resource stimuli and support, including funding. Pettigrew and Hendry (1991) found that although training can have an impact on broader, more strategic activity, for most firms it is often looked upon as simple routine decision-making: "training represented a tap which could too readily be turned on and off" (p. 33). This theme of managerial perception and choice is another point which is echoed in the present research particularly in the light of the Oxfordshire health authority case-study (see Chapter seven). Pettigrew and Hendry (1991) indicated that addressing a broader range of human resource issues such as career development, OD, and culture change processes is, perhaps, the most effective way to cement attention to training in organisations.

Another analysis as to why rate and pace of change differ in contrasting contexts is given by Pettigrew and Whipp (1991). They found an observable difference in the way higher performing firms managed strategic change from their counterparts over time. In the higher performing firms, change is the result of uncertain, emergent, and iterative process. There are no grand blueprints for long term success or quick fixes for immediate salvation. The process relies on the development and use of less immediately visible capabilities called "intangible assets" (p.26).

"Intangible assets include knowledge about markets and technologies and how to exploit them, as well as brands and reputation for quality of products, services and human resources. However, the most fundamental intangible assets, and those most linkable to competitive performance are organisational capabilities to learn and change" (p.1)

Firms that can develop such capabilities will be able to grasp opportunities quickly. The building process itself is, however, measured in years rather than months.

The ability of firms to learn and adapt over time relates to a set of five interrelated factors which provide high energy around change which in turn contribute to corporate performance: (1) environment assessment; (2) leading change; (3) linking strategic and operational change; (4) human resources as assets and liabilities; and (5) coherence. According to Pettigrew et al (forthcoming), the process and factors evident in higher performing commercial firms hold good in the DHAs processing high change agenda.

"All five of the factors are echoed in our higher change districts, and there are clear parallels between the private sector observations of the change process as uncertain, emergent, and iterative and what we have observed in the NHS" (p.12)

Pettigrew et al (forthcoming 1991) indicated that although the 1980s were marked by sustained top-down pressure to change, many central policies in the NHS,

including priority services, were being only "falteringly implemented" (p. 1) at DHA level. The CCSC study shows that districts facing similar environmental and policy pressures behave differently at times in achieving outcomes. Pettigrew et al (forthcoming 1991) suggest that the different experiences of DHAs reinforce one of the fundamental arguments that context may be a critical shaper of process. They argue that the differences in the rate and pace of change across DHAs reflect the differential receptivity of the local context for change. Pettigrew et al (forthcoming 1991) conclude that:

"the management of change is likely to be contextually very sensitive; that there is no quick fix or simple recipe; and that there is no one way in such a pluralist organisation as the NHS" (Pettigrew et al, forthcoming, p.2)

The features of context which, according to Pettigrew et al (forthcoming 1991), seem to be favourably associated with forward movement include: (1) the quality and coherence of policy; (2) the simplicity and clarity of goals and priorities; (3) the availability of key people leading change; (4) a supportive organisational culture; and (5) the fit between the district's change agenda and its locale; (6) the managerial clinical relations; (7) the cooperative interorganisational networks; (8) the

intensity and scale of long term environmental pressure. Although acknowledging that there may be a link between the criteria of receptivity and the content of the change issue or agenda, Pettigrew et al (forthcoming 1991) do not, however, contribute further to this debate, leaving it to further work to test the robustness of their findings.

The first five factors mentioned above are echoed in the present research. Clearly, the quality and coherence of the proposal generated at local level appear to have been influential. Probably the best example that it is not enough to take a dated central policy "off the shelf" to secure implementation at local level is the failure of the Wycombe DHA's first proposal to close the Amersham GPMU. The second factor, the simplicity and clarity of goals and priority, is also confirmed. The ability of the officers to reduce the problem and to uphold a clearly focused cause is well illustrated, particularly by the closure of the Abingdon GPMU in Oxfordshire, as well as by the closure of the Isebrook GPMU in Kettering. The third factor, the availability of key people leading change, is best illustrated by the closure of the Amersham GPMU in Wycombe. The leaders lacked the bureaucratic, as well as the political, skills to implement the first proposal whilst the new Chairman

and the DGM provided the necessary complementary skills to succeed the second time. The fourth factor, a supportive organisational culture for change, is evident in the Oxfordshire case-study where the openness to innovation and the district officers' belief in the virtue of the clinical approval dominated the implementation process. The fifth factor, the fit between the district's change agenda and its locale, is also confirmed particularly in Wycombe as well as in Milton Keynes case-studies where competing population centres struggle for the health services.

The remaining three factors, the managerial clinical relations, the cooperative interorganisational networks, and the intensity and scale of long term environmental pressure, seem less important in the present research than in Pettigrew et al (forthcoming 1991) study. These differences can be attributed to the types of service change investigated by each research. The CCSC study addressed the implementation of a number of current major strategic changes whilst the present research investigated the implementation of change falling within the category of "middle range decision-making" (Hunter, 1980, p.6). The former are likely to be more sensitive to environmental change and, therefore, to be triggered by intense and large scale environmental pressure (Pettigrew, 1985; Tushman

and Romanelli, 1985) than the latter. This suggests that the criteria of context receptivity are closely related to the content of the change issue investigated. The managerial clinical interface is likely to be more critical in implementing change in acute services than, for instance, in priority groups sector, whereas a cooperative interorganisational network is, perhaps, more important in implementing changes in priority group sectors than in maternity services.

Closing the "Implementation Gap": A Common Pattern

The GPMUs that have been described in the preceding four chapters were all, as far as the DHAs are concerned, successfully closed by 1991. The conceptual starting point of our analysis is that the achievement of change objectives could be explained by the interplay between the content of change, the context of change, and the process of change (Pettigrew, 1985). Keeping that in mind, the next section of this chapter analyses the narrative accounts presented in detail in the preceding chapters and highlights the factors and features which contributed to the districts' success in closing their "implementation gap".

A set of three interacting factors, derived inductively from the research, seem to have a

meaningful effect on the "implementability" of the proposals: (1) the nature of the DHA; (2) leading implementation; (3) the quality of the local proposal. These factors are detailed in Figure 10-1.

Figure 10-1

Some Important Features and Factors in Implementing the GPMU Closure Proposals

Nature
of the
Locale

Leading
Implementation

Quality of
Local Proposal

I THE NATURE OF THE LOCALE

Objective:

- a - Geography
- b - Competing Centres
- c - Major Hospital Sites
- d - Population Changes
- e - Strength of the CHC
- f - Network of Local Groups
- g - Socio-economic Structure
- h - Marginal Constituency

Subjective:

- i - Local Opinion
- j - Timing
- k - Past Mobilisation
- l - Culture and Beliefs
- m - Public Attitude

II LEADING IMPLEMENTATION

- a - Diversity of Leadership
- b - Sharing the Leadership
- c - Leader/ Champion
- d - Team Support

- e - Strategies
and Tactics

Enforcing

- . Arbitration
- . Temporary Closure

Legitimizing

- . Setting Climate
- . Reducing Services

Negotiating

- . Expectations
- . Opportunity Costs
- . Combinings
- Development and
Retrenchment

III QUALITY OF THE LOCAL PROPOSAL

- a - Soundness of the National Policy
- b - Facts and Arguments at Local Level

(I) The Nature of the District

The nature of the district was found to have an impact on the implementability of the closure proposals investigated. The main features of the locale are twofold: (1) objective, and (2) subjective. Of the former, the most important elements are: the geography of the district, the number of competing centres of populations and the major hospital sites in the district, the pace and rate of change in the structure of the local population, the strength of the local CHC and its access to wider support from the local network of interest groups, and the socio-economic structure of the district.

The difficulty of implementing the proposals also depended on the way the local population perceived their situation. The more subjective elements include: local opinion concerning health services, the timing of the proposal versus the national climate of opinion on the management of the NHS, the history of mobilisation around health care as well as other local issues, the culture of the locality, the attitude of the local population towards their local hospitals, and the local MP's political security in his constituency.

The impact of the locale on the implementation processes and outcomes has also been reported by Korman and Simons (1978), Hardy (1985), and Pettigrew et al

(forthcoming 1991). Korman and Simons (1978) highlighted the effect of the local culture on the difficulty to implement closure in a community geographically separated from other health services:

"Although consultation with other statutory bodies revealed doubts about the degree to which the local area was receiving poor services, the local community certainly thought it was, and this was the basis of its opposition" (p.173)

They also stressed the influence of the local MP and the political nature of closure:

"The local MPs constituted another external force. Right from the outset they were formative in initiating and continuing a dialogue with the RHB over proposals and decisions concerning Poplar. The fact that a Labour government was returned in February 1974 facilitated the influence they had, for it allowed three Labour MPs from traditional Labour areas to plead a special case with a Labour Secretary of State. This point emphasises the highly political nature of the question of Poplar closure" (p.175)

According to Hardy (1985), environmental factors are important in implementing closure, particularly because they contribute to the power resources of the different interest groups involved. This was particularly evident in Wycombe health district as well as in Milton Keynes where previous confrontation between the population centres involved, provided the opponents to the closure of the GPMU with a larger support base than it would have had otherwise. Pettigrew et al

(forthcoming 1991) argues that, although many of those factors may appear beyond management control, the awareness of their influence could nevertheless be important in anticipation of potential obstacles to change.

(II) Leading Implementation

Not surprisingly, perhaps, leadership was also an important factor in implementing the closure proposals. The best examples are provided by the successful proposal raised by the Wycombe DHA to close the delivery services in Amersham and by the successful closure of the Isebrook GPMU and children's ward in Kettering health district. There can be little doubt from the evidence of the present research, as well as from other studies on the issue (Behn, 1978; Hardy, 1985), that closures are generally uncertain, often threatening for those affected by them, and, therefore, difficult to implement.

"During the process of change conflicting interests will come to the fore. It is sometimes difficult to summon up and maintain the willpower to face up to conflict and have the tenacity to implement decisions. The process can, at best, be extremely demanding and often apparently unrewarding" (Dennis, 1980, p.12)

In such circumstances leadership is vital to raise the necessary enthusiasm to achieve implementation. As

Stewart (1989) indicated,

"Leadership is most needed in changing times, when the way ahead is not clear. A good leader should both show the way and make others feel enthusiastic about following it. Change can then, depending on its nature, become positive, exciting and challenging rather than discouraging and threatening" (p.3).

The most striking feature of leadership across the district investigated is that although the maternity units were ultimately all successfully closed, the ways key people at district level made the change happen differ substantially from one district to another. The diversity of leadership was also apparent in Pettigrew et al (forthcoming 1991) research on change in the NHS. Leadership, they suggest, is acutely context sensitive. The findings of this research seem to support that claim.

The central finding of the present research in relation to the leadership process in implementation is twofold. First the leadership behaviour in implementation appears to be less dramatic than often pictured in the literature. Second, the leadership task was generally shared by different individuals within the district as opposed to a single individual throughout the process.

This view that leadership behaviour in managing organisational change has much to do with routine processes as opposed to extraordinary episodes of

imagination, persistence or skill has also been reported by March (1981) as well as by Pettigrew et al (forthcoming 1991). As March (1981) indicated,

"Simply to describe leadership as conventional and constrained by organisational realities, however, is to risk misunderstanding its importance. Neither success nor change requires dramatic action. The conventional, routine activities that produce most organisational change require ordinary people to do ordinary things in a competent way" (p. 575).

According to Pettigrew et al (forthcoming 1991), the tasks of leadership in managing change are about the resolution of patterns of interwoven problems and require a combination of planning, opportunism and the adroit timing of interventions. The leadership task in managing change also involves, according to Stewart (1989), developing a strategy, particularly on how to enlist the necessary support for change.

The idea of sharing the leadership in implementing change has also been reported by Pettigrew and Whipp (1991). They suggest using the term "leading change" (p.27) rather than leadership to contrast the collective and multifaced aspect of the process with its image of individualism and heroism.

"The critical leadership tasks in managing change appear to be much more fragmentary and incremental than the popular images of business heroism allow. Leading change involves action by people at every level of the business" (Pettigrew and Whipp, forthcoming 1991, p.10)

In the narrower field of leadership in the NHS, the Templeton Series on DGM (1987) and Stewart (1989) pointed out that sharing the leadership can be found not only in the relationship between the chairman and the general manager but also in groups and sometimes in other relationships, particularly with doctors and subordinates.

"The overall lesson for any manager - but particularly a senior one - is that there are different aspects of leadership and that those often will - and should - be shared" (p.70)

The evidence of the present research indicates that the proposals to close the GPMU were clearly decisions by management and suggests that two aspects of leadership were more easily shared in implementing the closure proposals: championing the proposal and leading the closure process. These tasks were fulfilled by people of various hierarchical levels (Table 10-5).

Table 10-5

Leaders and Champions of Implementation

DISTRICT Proposal	Leader	Champion
Wycombe		
Amersham I	Chairman	Obstetrician
Amersham II	Chairman	DGM and DMO
Oxfordshire		
Abingdon III	Planning Adm.	---
Abingdon IV	Planning Adm.	Community Unit GM
Milton Keynes		
Westbury	District Adm.	DT and DMO
Bletchley	District Adm.	Commissioning Team
Kettering		
Isebrook	DGM	DGM

As Pettigrew et al (forthcoming 1991) suggest, it is often personalities and personal resources rather than formal status and rank within the organisation that are important. In such a division of work the champion provides the vision and points the way forward whilst the leader responsibility is to mobilise enough support and commitment to action from other members. Korman and Glennerster's (1990) analysis of the closure of the Darenth Park illustrates that the availability of a "champion" is a necessary but insufficient condition for successful implementation.

"It is still unusual in the NHS to find an officer willing to step out of standard operating procedures and openly take a leadership role on a controversial issue.

Without the regional nursing officer who did this, the Darenth Park Project would not have succeeded ... That was not enough however. More officers needed to meet regularly to chase the progress of multiple parts of the project and find solutions to practical problems as they arose ... One of the way in which this situation was overcome was to bring together a group of people who were committed to the Darenth Park Project" (p.61)

Pettigrew et al (forthcoming 1991) also found a similar pattern in their receptive contexts and stressed the leader's task of building a team of officers providing complementary assets and skills.

"It was a critical mass of enthusiasts with shared values that was important, rather than one individual champion of change. Partly this network formed organically, partly it was being orchestrated by the Chairman and was aided by stability in management, tempered by judicious appointments" (p.21)

Confronted with conflicting interests and the likelihood of resistance, the key people leading implementation ought to take conscious steps to secure implementation (Bardach, 1976; Behn, 1978; Ellis, 1983; Hardy, 1985; Pettigrew, 1985; Stewart, 1989; Pettigrew et al, forthcoming 1991). The analysis of the case-studies indicates seven managerial tactics falling into three categories or strategies which, although considered separately for analytical purposes, were often combined by the key people leading implementation: (1) the legitimating strategy; (2) the enforcing strategy and (3) bargaining/negotiation strategy (Table 10-6). The first strategy concerns the

use of "unobtrusive power" (Hardy, 1985, p.17) to secure acceptance and quieting possible opposition.

"Unobtrusive power incorporates the conscious use of symbolic power to legitimise desired outcomes to the extent that conflict is prevented" (p.20)

The two last strategies are concerned with "overt power" (Hardy, 1985, p. 16) being exercised in the face of opposition to defeat conflict and achieved results.

"Overt power refers to the mobilisation of resource interdependencies to defeat conflict" (p.20)

Table 10-6

Strategies and Tactics for Closure
Emerging from the Case-studies

STRATEGY -----	TACTIC -----
I Legitimizing Strategy	(a) Climate Setting; (b) Reducing Services;
II Enforcing Strategy	(c) Arbitration; (d) Temporary Closure;
III Bargaining/ Negotiation Strategy	(e) Reducing Expectations; (f) Opportunity Costs; (g) Combining Development and Retrenchement

The three strategies and the seven major tactics developed by the health districts investigated are concisely described below.

The Legitimizing Strategy

The legitimating strategy consists of various managerial actions primarily intended not to defeat opposition but, instead, to mobilise support and to prevent resistance from arising in the first place (Pfeffer, 1981; Pettigrew, 1985; Hardy, 1985). As Pfeffer (1981) pointed out,

"Power is most effectively used when it is employed as unobtrusively as possible. The exercise of power and influence is facilitated by the legitimation of the decision process, decision outcomes, and the power and influence itself. Most strategies for the exercise of power involve attempts to make the use of power less obtrusive, an attempt to legitimate and rationalise the decision that is to be made as a result of the exercise of the social power of an actor in an organisation" (p.137).

According to Hardy (1985), implementation is achieved by influencing the way people feel about the physical outcomes of closure such that it is deemed legitimate, inevitable or acceptable. Features of intra-organisational context and socio-economic context can be mobilised in order to achieve legitimacy (Pettigrew, 1985).

Three specific tactics for mobilising support and quieting opposition are particularly well illustrated

in the case studies: (1) climate setting; (2) opportunity costs; (3) and reducing service levels.

Climate Setting

As Pettigrew and Whipp (forthcoming 1991) indicate, moving directly to bold actions can be costly.

"Instead, the prior need is to build a climate for change while at the same time raising energy levels and setting out new direction to be followed before precise action is taken" (p. 10)

Building within the district a climate conducive to change, prior to focusing on the specific issue of closure, is probably the most complex and time consuming tactic illustrated in the case-studies. According to Hardy (1985) such a strategy requires, at least, two basic conditions: (1) creating credibility for management; and (2) genuine consultation. Here, the consultation process is primarily used as a "review system" (Korman and Simons, 1978, p.177) in which both proponents and opponents are able to contribute to the closure decision-making process:

"Those who are consulted may go over the same reasoning process to ensure that sufficient weight has been given to factors important to them" (p. 177)

A third condition for creating a receptive climate for change is to provide legitimate reasons for closure when the proposal is ultimately mooted.

The closure of the Isebrook GPMU and the transfer of the children's ward from Isebrook to the DGH by the Kettering DHA illustrate this tactic and show that it can be rewarding. The need for action to be undertaken was unchallenged even by the CHC. Although doubts were cast on the origin of the district's financial crisis, it provided enough legitimacy for both the closure of the GPMU and the transfer of the children's ward. The need for savings did not provide sufficient legitimacy for closing fully the children's ward, particularly because of the lack of attention to "the politics of timing" (Brewer, 1978) and because medical opinion was against it. As Hardy (1985) indicated,

"Reasons confer legitimacy, not because they are, in any objective sense, right, but because they are deemed legitimate by the group in question. Whereas finance may be an appropriate argument in the industrial sector, things become much more complex in the health sector ... There is, then, no absolute right or wrong with many medical arguments, and what may be perceived as right may simply be those actions which receive the largest amount of public approval by doctors and consultants. The task of management is in selecting appropriate criteria and securing visible support" (p.111)

Opportunity Costs

The concept of opportunity cost rarely enters into a public policy debate. As Behn (1978) indicated,

"The cost of initiating a new policy, for example, is expressed in mere dollars - not in terms of opportunities forgone. This is even more true when the policy choice concerns the closing of a government facility. Certainly a more significant benefit than mere money ought to be required to justify ending a service that, when it was instituted, was considered important and essential" (p. 333).

The second tactic of the legitimating strategy is illustrated by the Oxfordshire DHA closure of the Abingdon GPMU. It consists of regularly stressing the opportunity cost of keeping the facility open until either an acceptable alternative is found or opposition to closure simply disappears, therefore opening an opportunity for action. Consultation is then used essentially to keep the dialogue going, to assess the strength of resistance, and to test the feasibility of change.

Reducing Service Levels

The third tactic of the legitimising strategy consists of using every opportunity, as it arises, to reduce service levels in advance of the total closure. Such a tactic has also been reported by Ellis (1983):

"In addition to timing termination efforts with favourable conditions, administrators are also cautioned to take other preliminary steps prior to the actual termination. Some

of the most important are: precede the termination with negative evaluations of the programme; gain the support of superiors and warn them of the public outcry that might follow the termination and; cushion the blow of the termination by reducing the programme's service levels well in advance" (p.355).

Failure to achieve total closure following consultation, working parties' reports, and formal evaluation of services provide such opportunities. The consultation helps in deciding which new level of services will be accepted without substantial opposition. Both Oxfordshire and Kettering districts illustrate the strategy. The latter shows that the strategy contributes by creating a sense of inevitability and powerlessness among the interest groups concerned. Here, the case-studies illustrate that the shrinking and de-escalation of the change content can contribute in bringing movement into previously contentious and deadlocked processes.

The Enforcing Strategy

The enforcing strategy consists of using power and legal authority to defeat opposition. Basically, the strategy aims at imposing the closure and can be both demanding and of considerable importance. As Pfeffer (1981) pointed out,

"Enforcing one's way over others requires the expenditure of resources, the making of commitments, and a level of effort which can

be undertaken only when the issues at hand are relatively important" (p.4)

Two specific tactics for enforcing implementation are illustrated in the case studies: (1) arbitration; and (2) temporary closure.

Arbitration

This tactic simply consists of pushing directly forward and referring the proposal for Ministerial Decision regardless of the strength of local opposition. The main purpose of local consultation is then either primarily symbolic or, at best, to inform the various groups involved of the decision already taken by the authority. Such a strategy proved unsuccessful in Wycombe, particularly because of lack of attention to the bureaucratic process of closure, the high degree of political mobilisation around health care issue in the district, and the mishandling of the closure. It was, however, successful in Milton Keynes, where the problems associated with commissioning the new DGH provided sufficient legitimacy for the proposal to gain the approval of the Secretary of State, despite a solid case against closure by skilled opposition.

Temporary Closure

The second tactic, temporary closure, also uses legal authority to defeat opposition. As stated in the

King's Fund (1980) handbook on the administrative processes on closures,

"When there is no time for formal consultation on a substantial temporary closure or change of use, an authority should undertake full consultation immediately after the temporary closure has been made if there is a possibility that the authority might eventually wish, or be forced, to make the closure permanent" (p.18, emphasis added)

This tactic consists of closing the facility to assess and demonstrate the capacity of the interim arrangements to cope with the volume of services. Consultation is then used to inform the various interest groups of the thinking of the authority, both of immediate action and long term plans. Although the officers appear to have recourse to the tactic in an emergent as opposed to a deliberated way, the temporary closure of the Isebrook GPMU in Kettering DHA illustrates this tactic.

The Bargaining/Negotiation Strategy

The third strategy is bargaining and negotiation. The central objective is neither to defeat opposition nor to prevent resistance arising but to get something done, albeit at the expense of some of the original intentions. As Barrett and Fudge (1981) indicated:

"Without total control over resources, agencies and the whole implementation environment, those wanting to do something may be forced to compromise their original

intentions in order to get any action at all"
(p.21).

Both proponents and opponents used the consultation process in order to reach a mutually satisfactory compromise. The transfer of the Isebrook children's ward by the Kettering DHA illustrates this particular strategy.

Reducing Expectation

The first tactic of the bargaining and negotiation strategy is to reduce change expectations to known acceptable levels before consultation is undertaken in order to secure approval. Consultation is then basically used to promote managerial good will and to create credibility for managers. The closure of the delivery services at the Amersham General Hospital when the original intent was to close the GPMU altogether illustrates the tactic.

Combining Retrenchment With Development

Probably one of the most popular tactics combines retrenchment with development. Consultation is used to promote the new development allowed by the retrenchment, thus splitting potential opposition. The redevelopment contributes to minimising the impact of closure. As Behn (1978) pointed out,

"Any effort to minimise the impact will further reduce the short-run savings from the closing, but it can also help reduce the

political resistance. Those who receive direct benefits will be mollified, and political leaders who believe the closing is inevitable may, if they have a real opportunity to influence the transition, devote their energies to planning for the future rather than resisting the closing" (p. 336)

Examples of this strategy are the provision of additional community beds in Abingdon as well as the provision of a RRU in the space vacated by the GP maternity beds in Amersham.

Table 10-7 indicates the primary tactic adopted by each of the four districts investigated.

Table 10-7

Primary Tactic Adopted by the District

DISTRICT	TACTIC	OUTCOME
.Proposal		
WYCOMBE DHA		
.Amersham I	Arbitration	Failure
.Amersham II	Reducing Expectation	Success
OXFORDSHIRE DHA		
.Abingdon	Opportunity Costs	Success
MILTON KEYNES DHA		
.Bletchley	Development	Success
.Westbury	Arbitration	Success
KETTERING DHA		
.Isebrook GPMU	Climate Setting	Success
.Children's ward	Negotiation	Success

The central finding in relation to the closure strategies is that there are no simple universal rules.

Although the strategies and tactics vary across districts, all of them, ultimately, were closed. The detailed analysis of the case-studies made earlier in this chapter indicates that the general approach to the implementation adopted by each district also varies. That suggests that the choice of a particular approach, as well as the efficiency of a particular strategy or mixture or group of strategies, is highly context sensitive.

The question then becomes: in which contexts do the strategies seem to be appropriate? Again, the main limitation of this research relates to its small sample size, drawn from a single and not typical health region: the Oxford RHA has been a "laggard" (Rogers, 1983, p.249) in closing its GPMUs. Caution is therefore required in addressing this question. Nevertheless, evidence indicates that bargaining and negotiation can be a suitable strategy where both the objective and the subjective features of the locale are, on the whole, not conducive to the closure of the facility. This, perhaps, is best illustrated in Wycombe health district where the attempt to enforce total closure failed but the trade up of the delivery services for a rheumatology and readaptation unit succeeded.

In contrast, the enforcing strategy and tactics may be appropriate when both the objective and the subjective contexts are generally conducive to closure, yet resistance is manifested by some individuals. The best evidence is provided by Milton Keynes. There was certainly a great deal of activity designed to prevent the closure in the small market town of Newport Pagnell where the objective and the subjective features of the locale were not favourable to closure of the Westbury Maternity Home. The conditions in the district as a whole were, however, clearly more conducive to implementation and the opponents failed to take the issue out of the small local arena.

The aim of the legitimating strategy is to set a more conducive context in anticipation of the closure. The evidence, particularly in Kettering, indicates that the strategy is appropriate when at least some of the major objective and subjective features of the locale are already conducive to closure and, therefore, can be mobilised by the people leading implementation. In addition, strong leadership seems essential and continuity of leadership desirable because knowledge of locale is, perhaps, then at its best.

Ellis (1983) corroborated this finding:

"Each termination effort was initiated by administrators who sincerely believed that they had made the best decision given the scope of their responsibility and the limitation of their resources. What they failed to realise, of course, was that all aspects of an issue cannot be reduced to 'dollars and cents'. As a result of their lack of attention to the more intangible aspects of the mounted patrol, the administration was not sufficiently sensitive to the wants and needs of Miami taxpayers. Had there been greater continuity of the administration during this period, the officials would have undoubtedly realised that they were 'beating a dead horse', so to speak, that this was not an issue they should have addressed. Instead, they aggravated a no-win situation."

These conditions were also reported by Hardy (1985) in two of her case-studies where similar legitimating strategies were used: Camerons, a chemical factory, and Midville, a small cottage hospital. In the former case-study the factory was situated in a built-up area next to a hospital and it was considered wrong, even by the employees themselves, to make chemicals with so many people around, in case of an accident.

"The key factors in this case study are the appointment of Oppen and his management of the closure, including the initial culture change which set a firm foundation for a consultative approach to the closure ... Management was undoubtedly helped by the steward's perception of powerlessness, and the abdication of the union officials which left the stewards in a weakened position. Both of these groups found the decision to close Montside works acceptable, mainly for environmental reasons. Management was also helped by the existence of a non-militant

long-serving workforce which was loathe to take action against the closure." (Hardy, 1985, p.49)

The closure of the small cottage hospital also supports the findings, particularly with respect to the place of leadership in legitimating strategy.

"Midville was a rapidly expanding market town in the Midlands ... It had grown from a rural background and was not associated with high incidence of industrial activity or labour militancy ... The key factors here resolved around the existence of a powerful chairman, who had the support of management at both the area and the district level. He had initiated a climate setting exercise, similar to that undertaken at Camerons, several years before the closure, so that a constructive atmosphere existed before the closure became an issue. Once the closure was underway, management relied on consultation, communication and explanation, again, in much the same way as Camerons" (p.72)

Further research is clearly needed to establish more precisely which features of context are particularly influential in closing facilities and when the strategies and tactics are especially appropriate.

The analysis broadly supports the view expressed in recent studies (Pettigrew, 1985; Baier et al, 1986; Korman and Glennerster, 1990; Pettigrew et al, forthcoming 1991) that clear indication and strong commitment to action coupled with a broad vision as opposed to a detail blueprint, at least at pre-consultation phase, can contribute by easing some of

the implementation difficulties. As Pettigrew et al (forthcoming 1991) indicated:

"Such broad visions were found to have significant process and implementation benefits in terms of commitment building and allowing interests groups to buy into the change process, and allowing top down pressure to be married with bottom up concern as the field gets scripted in rather than scripted out" (p.17).

(III) Quality and Coherence of the Proposal

Together with the nature of the locale and leading implementation, the quality of the proposal itself was also found important, particularly as the power of the district to close the facility is limited. As Brewer (1978) indicated,

"Generally, it can be said that termination demands prior guarantees that changes - to programs, institutions, and affected publics - will leave the aggregate or net situation better off. However, the burden of the proof for this guarantee resides with those who wish to end something, and their evidence, if not their relative or situational power, must be nearly overwhelming (p.339).

The need to develop a solid case for closure based on sound facts and well-reasoned argument is clearly supported in the research. Although this point might appear a truism, the evidence of the research indicates that the data and the rationales for closure were often lacking.

Providing sound facts and clear arguments is, however, not an easy task, particularly as the

soundness of the policy itself is controversial. As Barrett and Hill (1983) and Baier et al (1986) indicated, unresolved problems, and compromise to get sufficient support for the policy at macro-implementation level are likely to spring back again and add further complications at micro-implementation level. The argument on the safety of the peripheral GPMUs is a good example of such an unresolved issue.

The importance of the quality and coherence of the proposal has also been reported in Pettigrew et al (forthcoming 1991). They suggest that analytic considerations represent, perhaps, necessary conditions while sufficient conditions relate to attention being paid to processes of negotiation and change.

The quality of the data substantiating the local closure proposals would, perhaps, be less necessary if the district officers could implement them themselves without having to convince anybody. But the decision-making power to close local health facilities is shared with a number of conflicting interest groups, particularly with the CHC. The situation at local level is one of "behavioural-interdependency" (Pfeffer and Salancik, 1978; Pfeffer, 1982):

"In the case of behaviour interdependence, the activities are themselves dependent on the actions of another social actor. Organising a poker game is an example of behavioural interdependence. In order for one person to play poker, it is necessary that he

or she convince others to participate in the game, which involves having them at a certain place at a certain specified time. If the others do not cooperate, then the person cannot engage in the activity of playing poker" (Pfeffer and Salancik, 1978, p.41)

In order for a DHA to close local facilities, it is necessary that the officers convince the CHC and other local groups to close them. The situation contrasts sharply with the context reported by Peters and Waterman (1982) in arguing for less "paralysis-induced-by-analysis" (p.49) and more bias for action in organisation.

"Even though these (excellent, innovative) companies may be analytical in their approach to decision making, they are not paralysed by that fact (as so many others seem to be). In many of these companies the standard operating procedure is do it, fix it, try it. Says a DEC senior executive, for example, when we've got a big problem here, we grab ten senior guys and stick them in a room for a week. They come up with an answer and implement it" (p.13, emphasis is original)

The point that is being made is important: the role of analysis is inextricably linked to the social interactive context and processes surrounding it (Langley, 1989).

"The more decision making power is shared between people who do not quite trust one another, the more formal analysis tends to become important. Formal analysis is often done to obtain information (as the normative literature suggests), but people also use it for communication, direction and control, and for its symbolic value in conveying messages of rationality, concern and willingness to

act. Analysis may help to determine the content of decisions, but it also acts as glue - binding the decisions of different individuals together to create an organisational decision. To understand the role of formal analysis in organisations, we must understand how it is related to the social interactive context" (p.342)

The Common Pattern: Concluding Summary

The second section of this final chapter has examined the key features of implementing the closure proposals and drawn the common pattern emerging from the data. As in the first section of this chapter, the main themes of the preceding discussion can be summarised as a set of simple statements:

Three sets of factors had an effect on the implementability of the proposals: the nature of the district, leading implementation, and the quality of the local proposals.

The first set, the nature of the locale, includes two types of factors: objective and subjective. These factors are important because they contributed to the power resources of the groups involved (Hardy, 1985).

The second set of factors, leading implementation, is also important. The central findings in relation to the leadership process is twofold: leadership is less dramatic than often pictured in the literature, it is generally shared by different individuals.

Three strategies and seven tactics used by the key people leading implementation were identified and concisely described. Further research is clearly needed to establish more precisely in which context the strategies and tactics are appropriate.

The bargaining strategy was successfully used when both objective and subjective local conditions were not conducive to implementation.

In contrast, the enforcing strategy was successfully used when both sets of conditions were conducive to closure.

The legitimating strategy seems appropriate when at least some of the objective and subjective conditions are conducive and can be mobilised by the people leading the closure. In addition a strong leadership appears necessary and continuity of leadership desirable.

Together with the nature of the locale and leading implementation the quality of the proposal itself was also found important because the decision making power of closure is shared, particularly with the CHC. The role of analysis is linked to the context and process surrounding it (Langley, 1989).

Chapters five to nine add further empirical evidence to the existing literature on implementation. The next section of this final chapter examines empirically the validity and power of each distinctive approach as a "single analytical lens" (Van de Ven, 1986, p. 597) to investigate implementation phenomena.

The Theoretical Approaches to Implementation: An Assessment

In Chapter two, attention was drawn to the growing theoretical pluralism in the implementation literature reflecting partly the multiple processes concurrently at work, partly the variety of contexts and content areas investigated, and partly the various theoretical frames of reference adopted by the researchers. Care

has been taken throughout this dissertation to avoid what Pettigrew (1985) calls "premature theoretical ethnocentrism" (p. 41), i.e. to pursue and refine from the outset a singular perspective or a particular approach dictating relevances in data, concepts, and hypotheses beforehand.

"I issued a warning to the reader and myself - beware of the singular theory of choice and change. Behind this warning was the obvious desire to avoid premature theoretical ethnocentrism, especially as I have shown the analyst of process does actually have a choice of perspective, if not theories, available" (p.41)

The type of logic is recognisably akin to Glaser and Strauss' (1967) "Grounded Theory" suggesting that theoretically sound and useful research findings are those which are substantially inductive, out of the examination of the data.

After the empirical investigation made in chapters five to nine, the examination of the district responses to the national policy, and the search for a common pattern in the features of implementing the proposals, the time has now come to return to the theoretical approaches.

Without rehearsing comprehensively the arguments of Chapter two, it is important in setting the scene for assessing the descriptive validity and the power of the theoretical approaches to call to mind their key

The first dimension distinguishes between the organisation as a technically constrained system and the organisation as a social construct. The former contends that organisational behaviour is cohesive and rationally contrived towards the instrumental attainment of goals. The view of organisation as a social construct suggests that the system is an aggregated outcome of subjectively meaningful individual acts (Astley and Van de Ven, 1983).

The second dimension relates to the models of man underlying the theoretical approaches. It uses the traditional duality between voluntaristic and deterministic views of behaviour. The voluntaristic view suggests that individuals are autonomous, proactive, self-directing agents capable of adjusting the various conditions to meet their ends. The deterministic view assumes that people's behaviour is determined by exogenous forces and constraints (Van de Ven and Astley, 1981, Pettigrew, 1985).

Table 10-0 shows that both the classical approach and the contingency approach assume that organisations are technically constrained systems. However, the former views human behaviour as voluntaristic whereas the latter views it as deterministic. The political and the behavioural approaches assert that organisations are social constructs. Although there is considerable

diversity and debate between the classical and the political approaches, they share a common voluntaristic view of human behaviour whereas the contingency and the behavioural approaches take up a deterministic view on that issue.

The Classical Approach

The various perspectives of the classical approach adopt the rational-analytical view of intentional process and outcome. In the main the approach rests on the assumptions that formulation and implementation are two discrete entities with implementation the means of putting well-thought-through intentions into effect. The proposal is selected among a number of alternatives which are formally assessed through rational debates. Once formulated the proposal is expected to be automatically implemented through methodical and sequential action undertaken by a small group of top managers who have the capacity to change the organisation, the authority to make the decision, and enough influence to obtain compliance.

Recalling the evidence of Chapter five, there can be no doubt that the formulation of the policy and its implementation were two discrete entities. On average, sixteen years separated the closure of the local GPMUs investigated from the national pronouncement. There was also a division between formulation and implementation

at local level. Here, the split between formulation and implementation can clearly be linked to the statutory requirement to produce a consultative document before closing the health facility.

Evidence that the outcome of the implementation process does not always match the original formulated intentions can, however, be found in all four districts investigated. It is particularly true in Wycombe where, at the time of the first proposal, the re-opening of the Amersham GPMU was obviously not the aim pursued by the district officers, neither was the closure of the whole GPMU the expected outcome of the second proposal. Another example is the series of proposals to close the Abingdon GPMU in Oxfordshire. Ironically, it was during a period when the closure of the maternity unit was considered undesirable by the district officers that it was finally achieved. Similarly, the proposal to close the Isebrook GPMU was implemented in spite of the district stated intention in its Strategic Plan to retain it.

There is evidence that the process also does not always work as intended. The RHA decision not to support the change of use of the Bletchley GPMU in Milton Keynes, as well as the delay prescribed by the Secretary of State in achieving the centralisation of all maternity services in the new DGH, also illustrate

that the implementation process is often not working entirely as intended.

The evidence suggests, however, that the initial intentions were not as carefully analysed and well-thought-through as the classical approach suggests they should. Again, the classic case is provided by the Wycombe DHA. The first proposal to close the Amersham GPMU is perhaps the most obvious example giving evidence to this point: the national policy was simply taken off the shelf by the consultant obstetricians who championed the closure regardless of the performance of the maternity unit and local circumstances. Although the intention of the second proposal was more thoroughly investigated, it is clear, in retrospect, that the officers were over-cautious in their proposal to close only the delivery services. In any case the second proposal was clearly not the outcome of a formal assessment of numerous alternatives through rational debates but the result of various political compromises. The closure of the Isebrook children's ward provides another example of a proposal based on a faulty analysis. The officers appear to have made a mistake, even in their own words, in assuming that the children using the facilities did not need hospital care.

The relatively large number of unsuccessful closure proposals in all four districts investigated illustrates clearly that intentions are not automatically implemented. Although the district officers had the authority to make the proposal, the evidence indicates that they do not necessarily have either the capacity or sufficient influence to obtain compliance and to secure implementation.

In conclusion, the analysis supports the claim already made by Allison (1971), Pettigrew (1973, 1985), Elmore (1978), and Hardy (1985, 1986), among others, that the classical approach is not an adequate explanation of behaviour and events. The processes and outcomes of implementation were not entirely intentional, neither were the intentions carefully analysed; alternatives were rarely considered and, therefore, hardly assessed through rational debates; officers had the authority to make the decision but they did not necessarily have the power and the capacity to implement change. Implementation was not automatically secured but often resisted.

The Contingency Approach

The perspectives of the Contingency Approach also adopt the rational-analytical views of intentional process and outcome. The basic premise of the contingency approach is that the top decision-makers

have a variety of structural forms and organisational processes from which to choose in implementing change. The key to successful implementation is to rationally design an organisational structure together with a set of consistent organisational mechanisms which fit both the characteristics of the environment of the organisation and the requirements of its strategy.

The contingency approach does not inform the present study of implementation for two main reasons. First, the analysis requires a processual theory whilst the structuralist perspectives on organisations are essentially determinist. They assume that the strategy is an optimal solution falling into line with various demands dictated by the environment which only permit certain ordained outcomes. Strict and instant obedience is automatically secured through economic constraints and market selection mechanisms.

Second, although the closure of a GPMU involves more strategic levels of choice than is the case with simple routine decision-making, it does not have the magnitude to call for change in the districts' organisational structure nor in their organisational mechanisms. Therefore, the case-studies do not provide the necessary evidence to assess the descriptive validity and analytical power of the contingency approach.

Indirect evidence, however, is provided which informs the debate between strategy and structure. Earlier in this chapter the periods of high level of change activity have been associated with the shifting emphasis towards firm central control in the evolution of the DHSS relations with the local health authorities. These periods featured major change in structure and/or in organisational mechanisms at national level which, in turn, have been followed by change in local service strategies.

The Behavioural Approach

The Behavioural Approach assumes that resistance needs to be overcome in implementing change. The way change is communicated to people, the participation of the people concerned in the decision-making process as well as the role and skill of the leaders are all critical factors in overcoming resistance to implementation. The careful selection of top managers, attitude changes, and the rethinking of the organisational culture are also advocated as important.

The empirical evidence reported in the present research clearly supports the view that overcoming resistance is an important aspect of implementation. All the case-studies, including the relatively easy closure of the Isebrook GPMU, feature some sort of resistance. However, the most obvious example is,

perhaps, the closure of the Amersham GPMU by the Wycombe DHA where the first proposal was opposed by a wide range of interest groups including GPs, the local councils, the CHC, and a number of national bodies. The case-study clearly demonstrates that resistance can increase as a result of managerial mistakes in handling the process of implementation.

A number of case-studies illustrate that the way change is communicated to people is important. The closure of the Amersham as well as the closure of the Isebrook paediatric ward show the importance of analytical soundness in generating the data and framing the issue to convince the people likely to resist implementation in the district. Pettigrew et al (forthcoming) also provide evidence that, analytically, the quality of the data played an important part in substantiating a solid case, especially in relation to convincing the members of the medical staff. Closure that comes as a complete shock may evoke hostile reaction and increase the likelihood of resistance (Hardy, 1985).

Of the four DHAs investigated in the present research, Kettering DHA provides, perhaps, the best example of "integrative structure and culture" (Kanter, 1983; Pettigrew, 1985) and cooperative mode of problem-solving. The closure of the Isebrook GPMU and

children's ward illustrates clearly that participation of the people concerned in the decision-making process had an important part to play in building up the commitment from the CHC and allowing other groups to buy into the change process.

All the cases indicate the importance of leadership skill in implementation. The best example is, perhaps, provided by the contrast between the leadership of the first proposal to close the Amersham GPMU and that of the second proposal. There is also sufficient evidence to support the view that culture can play a key part in implementation. This is especially evident in Oxfordshire where a strong positive self image of being different, an openness to innovation, and the officers' belief in the virtue of the prerequisite clinical approval clearly dominated the process of implementation in the district.

The behavioural approach appears capable of providing a convincing account for some elements of the processes investigated in the present research. Clearly, there is considerable support for the need to overcome resistance. Attention to the analytical soundness in generating the data and framing the issue, participation of the people concerned in the decision-making process, leadership skills have been found important factors in doing so.

The Political Approach

The Political Approach adopts a pluralist view (Cyert and March, 1963) which not only acknowledges the existence of conflict, as the result of different interest groups competing from scarce resources, it also provides an analysis of why and how it arises.

Political action is only possible if the participants have access to power. The access to power is, however, an insufficient condition for success; political actors must also be aware of their power as well as to control and use it tactically (Pettigrew, 1973). They must have the willingness and the ability to translate their awareness into effective action to make and prevent changes from happening.

Power can be utilised in two ways: (1) to defeat opposition, and (2) to prevent resistance from arising (Pfeffer, 1981; Hardy, 1985). In the former, the actors rely largely on resource dependency considerations and attempt to impose their decisions whereas, in the latter, the actors use symbolism, language, belief, and myth to create legitimacy for their demands and to delegitimise the demands of their potential opponents.

It is clear from the evidence provided that the division of labour tends to create conflict and release political energy, particularly in closing health

facilities. The most obvious example of conflicting interest is, perhaps, the split between the DHA and the CHC laid down by the NHS regulations. Although the DHA has the authority to close the facility, the CHC has considerable power because of its statutory obligation to be consulted. Clearly, the decision of the Secretary of State to re-open the Amersham GPMU in 1985 illustrates it. The Milton Keynes case-study demonstrates that both the DHA and the CHC can use their power sources to promote their own interests; the DHA was keen to be seen as efficient, particularly by the RHA, whilst the CHC was concerned to establish its reputation, especially in public.

But the DHA and CHC are not the only conflicting groups in implementing closure of health facilities. The Isebrook children's ward illustrates the power of the medical staff in resisting closure promoted by the district officers to achieve financial saving. The conflict is not limited to the managerial clinical relations but also within the medical staff itself. Clearly, the frames of reference of obstetricians in Wycombe and GPs in Amersham differ as to both the nature and the safety of delivery process. These differences also lead to conflicts.

The case-studies provide evidence of a number of other conflicting groups: the Bletchley GPMU

illustrates the conflicting interests, as well as the differing time orientations, between the new DHA attempting to open its District General Hospital and the RHA long term plan for community hospitals; the Isebrook GPMU shows the conflicting interests between the staff threatened with losing their jobs and the DHA in search for savings; the Amersham as well as the Westbury give examples of the conflict between community groups and local councils and the DHAs.

The view that the awareness of power is an important condition for success is clearly illustrated in the case-studies, particularly in the first attempt to close the Amersham GPMU. The most eloquent example is, perhaps, the refusal of the local GPs and the CHC to agree formally that the consultation over the closure of the GPMU had been satisfactory despite the RGM's endeavour to get such a statement before referring the closure proposal forward to the Secretary of State for decision. Although they admitted that the outcome of the consultation would not have been any different, they refused to give up their power and insisted that the formal consultation process had not been properly followed, threatening to take action against the Secretary of State if the closure was approved.

Evidence indicated that, in contrast to Milton Keynes, the opponents in Wycombe were willing to use all their power and to offer more than rational arguments to keep the maternity unit open. It is clear that they had the necessary skills to escalate the problem and to mobilise fear for the future of the local hospital in the locality to save the GPMU. Although the opponents to the closure of the Westbury Maternity Home in Milton Keynes also had the skills and particularly the power of expertise in the field of statistics and population projections, they did have the will to use all their power resources to win the issue. For instance, they did not search to get medical support for their campaign and played down the "emotional" reasons for keeping the facility in Newport Pagnell.

The idea that power can not only be used to make change but also to prevent it from surfacing is echoed in the case-studies. This is particularly clear in Oxfordshire where the medical staff controlled the agenda. In this case, staffing innovations were introduced and change of use of maternity beds were made in order to prevent closure proposals based on savings from arising as decision issues.

The use of power both to defeat opposition and to prevent conflict arising has been discussed in the

previous section. The Milton Keynes case-study illustrates that legal authority can be used to impose closure. In this case, the proposal was simply referred to the Secretary of State for approval. The closure of the Isebrook GPMU, in contrast, illustrates the use of power to reduce the likelihood of opposition. In this example the district officers took a number of steps over the years to explain the financial position of the district, particularly to the staff and the CHC. They widely consulted on the selection of actions which should be undertaken. Great pains were taken to ensure that all the people involved were fully aware of the pressures which necessitated the closures. Furthermore the officers made sure that the proposals were justified on the basis of acceptable criteria. The explanation for the reasons behind a closure is an important element in the management of meaning (Hardy, 1985). Although the district financial crisis resulted, at least partly from the senior officers' lack of financial control, the closure was justified primarily due to lack of funding from the RHA and the DHSS. At the time the proposals to close the maternity unit and the children's ward were mooted, the question of funding the NHS was at the top of the national political agenda (see Chapter five). The underfunding of the health services was a running theme in the

national media and, therefore, was deemed legitimate by the local population.

The Approaches to Implementation: A Concluding Summary

So, which of the theoretical approaches to implementation offers the greatest value in describing and explaining the processes and outcomes investigated in the present research. Perhaps not surprisingly, the analysis above indicates that a mixture of political and behavioural approaches offers the best potential value. There are three main reasons for the findings. The first relates to the content of change investigated: given the disruptive and threatening nature of closure, its prospect is bound to release political energy. As Hardy (1985) indicated:

"There seems little doubt that power and politics are likely to play a particularly important role in the discussion of closure. Political behaviour often features in situations in which the existing pattern of resource sharing is threatened. One such example is major innovation when opportunities to seize new resources are opened up (Pettigrew, 1973, Mumford and Pettigrew, 1975, Mintzberg, 1983). Another example is that where resources decrease, positions are threatened, and political behaviour may become necessary in order to safeguard interests" (p.13)

The second reason relates to the context of change: considering the politicised context in the NHS and the requirement for consultation bringing in a number of

groups with conflicting goals, politics is a likely result. As Korman and Simons (1978) pointed out,

"The parochial views of those being consulted may give different weightings to particular factors than would management and thus lead to different decisions. Participation may temper rationality, depending on circumstances and strength of opposition. Professional groups may, through local practitioner views of acceptable standards or through their national bodies, create constraints on management, limiting alternatives available. CHCs, because their opposition forces the decision on closure to the Secretary of State, are able to insist that the rationality of a decision be scrutinised by those who up to that time have not been party to the decision" (p.182).

Finally, the third reason relates to the process of closure. There is a clear need to build up commitment and ownership in change. Evidence that overcoming resistance is a critical aspect of implementation can be found in all case-studies analysed in this research. Therefore, the behavioural approach, combined with the political approach, offers the greatest value in explaining the process and outcome of implementation of closure.

Summary of the Findings and Conclusion of the Dissertation

This dissertation aimed to study the "implementation gap". It reported evidence on progress in implementing closure of health services at micro-implementation level. Specifically, the research developed an historically bound, processual, and contextual account of the development and fate of permanent closures of General Practitioner Maternity Units (GPMU) in four neighbouring Oxford DHAs.

The major objectives of this study were: (1) to illustrate and analyse the process by which the "implementation gap" is closed in practice at micro-implementation level and (2) to identify some of the potentially important factors which might help explain the pace and rate of change differential across health districts.

The key questions guiding the study included: was there evidence of variability in the rate and pace of implementation in districts facing broadly similar policy pressure? what affects the pace of implementation? why is it that centrally-formulated policy is not implemented ipso facto as prescribed? why do districts fail or succeed in implementing change desirable by the DHSS in the provision of local health care services? what affects the "implementability" (Quick, 1980) of the GPMU closure proposals?

This research has made two main types of contribution: (1) theoretical, and (2) empirical, as summarised below.

The Theoretical Contribution

The research has successfully built a bridge between organisational theory and public policy literature on implementation. A comprehensive review of the literature, of interest to both policy scientists and organisational theorists, was undertaken. Seventeen differing theoretical perspectives for studying implementation were identified. Simplifying the question as far as possible, an original framework for classifying the various perspectives was developed and the alternative perspectives were clustered into four categories inductively derived from the review: the classical approach, the contingency approach, the behavioural approach, and the political approach. A metatheoretical scheme for classifying the approaches and perspectives to implementation was further elaborated using two fundamental dimensions: the nature of organisation and the nature of man's behaviour.

The four theoretical approaches and their perspectives were summarised and their respective strengths and weaknesses highlighted and discussed. The analytical power and descriptive validity of those

approaches were further tested on the basis of the evidence of the research. Although it was found that, analytically, data played an important part in implementing the proposal, the classical approach was dismissed. The rationality of the closure proposal itself does not secure its implementation; it is the symbolic value of the process of formulation and its outcome which, in conveying messages of rationality, concern, and willingness to act, is important in enabling intentions to become actions. It was found that, because of the disruptive and threatening nature of closure, the politicised context and requirement for consultation, and the need to reduce resistance and to build up commitment and ownership in change, a mixture of behavioural and political approaches offers the best potential value in describing and explaining the processes and outcomes of implementation investigated.

A number of important conclusions were made. The traditional claim that too little attention has been paid to the question of implementation was dismissed as was the evolutionary explanation that the different models of implementation represent a shift away from the classical approach and a trend towards increasing sophistication in thinking about implementation. The volume of literature on implementation is now enormous. An alternative, and more satisfactory, explanation for

the diversity of perspectives was provided. It was argued that the number of perspectives is partly accounted for by the diversity of processes concurrently at work in implementing change, as well as by the skills and variety of conceptual frames of reference of the social scientists who have investigated the phenomenon, and by the variety of contexts and contents which have been studied by the various scholars.

The research on the implementation of closure in the NHS was reviewed to draw out what it has to say about either the content, the context, or the process of implementation itself. A critical analysis of the research was then carried out: each study was individually summarised, its contribution emphasised, and its major shortcomings clearly pointed out. It was found that, although important progress has been made since the first study on closure in the NHS was carried out only thirteen years ago by Korman and Simons (1978), the critical focus has generally been on structure rather than action, on RHAs rather than DHAs, and on psychiatric rather than on acute and maternity services. The present research has focussed on the action of the DHAs in implementing closure proposals in maternity services.

To make further progress towards an understanding of implementation, the present research adopted a new, eclectic, and integrative approach: the Contextualist approach. One major theme underlying most of the results and ideas presented in this dissertation is that the outcome of implementation can be explained by the interplay between the content of the proposal, the context of implementation, and the process of implementation itself.

The first and most influential contextualist research was Andrew Pettigrew's (1985) study of ICI, The Awakening Giant. Although other members of the CCSC, University of Warwick, have investigated various aspects of the management of change, including that in the NHS, the present research is the first to have examined it empirically and systematically using the concept and language of implementation in the area of closure of health services.

The Empirical Contribution

The research also probed the notion of implementation in an empirical sense. The unique contribution of the research has been to develop an historically bound, processual, and contextual account of the development and fate of four permanent closures of GPMUs in England during the 1980s.

The research provides a contextualist treatment of the development of central government policy in the maternity services area since the beginning of the century. Although other studies, such as Korman and Glennerster (1990) and the CCSC series on the management of change in the NHS, have touched on health service policy, the present research is the only research of its kind offering such an extensive treatment of the changing policy context under investigation.

Although the aim of the policy has remained the same since the beginning of the century, the policy itself has changed entirely from universal home confinement to universal hospital confinement and centralisation of all in-patient maternity beds in the DGH. Change in the policy was found to be generated by a mixture of political and socio-economical factors at national level combined with specific clinical changes. Here, two important findings were made. First, most changes in the policy were not radical but incremental, although not continuous. Second, policy changes were generally reactive as oppose to proactive. One of the key features of the current policy is that it is largely based on controversial beliefs that integrated GPMUs are safer and more economic than peripheral units.

It was further found that the policy has been implemented relatively rapidly throughout the country. The trend towards closure was precipitated further by economic recession. One of the key findings is that the pace of implementation of the policy has not been uniform throughout the country. Building on the work of Rogers (1983), the analysis indicated four groups of health regions: the early adopters, the continuous adopters, the non-adopters, and the late-adopters which includes the Oxford health region investigated in the present research.

The study has collected extensive and in-depth information on the implementation of GPMU closure proposals in four DHAs. Such detailed and comprehensive empirical studies of how local health authorities struggled to close the "implementation gap", are still rare. It is rarer still for questions of rate and pace to be posed in a context of research where the content and the outer-context framing the implementation process are similar. The present research is one of the few addressing these questions and the only research on the implementation of GPMU closure proposals in neighbouring and apparently similar districts. It adds to the data base of a limited number of studies which, in the last six years, have developed the contextualist approach. In

particular, this study also adds further empirical case-studies to the CCSC data base on the management of change in the NHS (Pettigrew et al, forthcoming 1991) and on the management of closure in particular (Hardy, 1985; Korman and Glennerster, 1990). It is the first to investigate partial as opposed to total closure of hospitals within the context of the NHS.

The evidence clearly indicated that apparently similar districts, although located within the boundaries of the same health Region, can adopt different service strategies and rate and pace of change. Compliance with national policy has not been homogeneous nor automatically secured across districts. This variability indicates that there was substantial discretion for autonomous action at local level: the conduct of the local authorities was not entirely determined by the policy but was found to result from processes of local choice. Policy might not always be a purely mandatory and prescriptive statement, as much of the public administration literature generally assumes.

The analysis of the diary of change across these districts indicated two periods of high level of change activity: 1976 to 1978 and 1982 to 1986. These periods were linked to UK economic downturns and with their associated effects on public expenditure, as well as on

the centre-periphery relations in the NHS. It was found that environmental forces and top-down policy pressure for change were, however, insufficient to create the will for implementation at local district level. No matter what the strength of those forces and pressures, they were only efficient in triggering the implementation process if the people were willing to act. A mixture of such broad forces, and pressures, and specific local problems and opportunities was found to be necessary to trigger off the implementation process. The overall pattern was for implementation to be precipitated by local problems and opportunities, followed by a renewed consciousness of national policy which was then mobilised to enhance the legitimacy of the closure proposals.

A set of three interacting groups of factors was found to affect implementability and rate and pace of change at micro-implementation level. The first was the nature of the locale. Objective factors, such as the geography of the district, the number of major competing centres of populations, and the pace of population change, were found to be significant. Subjective factors, such as the timing, the culture, and the attitude of the local population, also appeared to be important. This research supports Hardy's (1985) findings that those objective and subjective factors

were important because they contributed to the power resources of both the proponents and opponents to implementation.

Leadership was also found to be crucial. The central finding in relation to leading implementation supports the contention that "leadership is acutely context sensitive" (Pettigrew and Whipp, forthcoming 1991). The tasks in leading implementation were found to be less dramatic, more incremental, as well as more fragmented than generally thought; evidence of leadership sharing as described by Stewart (1989) was reported in all case-studies.

Eight specific tactics, empirically sound and used by the people leading implementation, were found, described, and illustrated using the evidence of the research: arbitration, climate setting, opportunity costs, reducing level of services, reducing expectation, temporary closure, incentives, and negotiation. These tactics were classified into three categories or strategies: enforcing strategy, bargaining and negotiation strategy, and the legitimating strategy. In the same way that the leadership is highly context sensitive, so is the efficiency of a particular strategy. Although an attempt has been made to specify in which contexts the strategies seem to be most appropriate, the research

has not, however, been able to assess clearly the specific conditions required for the strategies to be successful. Further research is therefore required.

Finally, the quality of the proposals was also found to be important. Failure to develop an analytically sound proposal and to justify the decision, risks increasing the power of the opposition and may lead to failure. In the past, the descriptive literature emphasising political processes in organisation generally has tended to dismiss the quality of the decision itself, together with the classical rational actor approach. The findings of the present research call for the soundness of the proposal to be re-introduced in the political analysis of implementation.

This research will not conclude with the traditional call for more research. Rather it ends where it all started: with the words from Pressman and Wildavsky (1979) which first prompted my interest in studying implementation.

"Implementation is worth studying precisely because it is a struggle over the realisation of ideas. It is the analytical equivalent of original sin; there is no escape from implementation and its attendant responsibilities. What has policy wrought? Having tasted of the fruit of the tree of knowledge, the implementer can only answer, and with conviction, it depends ..."

APPENDIX A

INTERVIEW FORMAT

While there was not a specific set of questions asked in each of the research interviews, there was a general format for the interviews. The archive material phase of the research provided a useful basis for asking some specific questions regarding the development of the sequence of events. Interviews lasted, on average, for about one hour.

Each interview was initiated with a description of the research topic and an indication that other DHA/CHC were also participating in the research.

A The INNER context of implementation

History Considerations

What was the history of the district/unit and what traditions have built it up?

Needs Considerations

What were the particular needs of the district?

What were the main financial pressures?

Was there any imbalance in services?

What was the population that the maternity unit served?

Was this the same as the catchment population designated by the Region for maternity services in this district?

What was the workload?

Were staffing levels and performance substantially the same as that in other districts?

What changes have occurred?

Was the unit used solely for maternity services?

What was the condition of the buildings?

Were the resources available for necessary improvements?

Organisational Inter-Relationships

What relationships did the district have with the CHC, the trade unions and any local pressure groups? Please provide details of:

- * Formal and informal relations between the CHC and the District;
- * Mechanisms for maintaining these relationships;
- * Perceptions of CHC Chairman and Secretary, their style and degree of competence;
- * CHC reactions to recent closure proposals;
- * Role of the CHC;
- * Climate of industrial relations and level of union activity and professional association;

- * Climate of relations with the medical staff;
- * Quality of relations with District, parish and city councils in the area;

Who were the key individuals participating in the closure of the unit?

Which members (if any) of the following groups were most significantly involved?

- * DHA members
- * Consultant Obstetricians
- * Local GPs
- * Midwives/Nurses
- * Trade Unions
- * Local Authorities
- * Committees
- * "Save Campaign"
- * Local MPs
- * Regional Officers

How did they form a coalition?

Which tactics did they use to strengthen their position?

Leadership and "product champion"

Was there a coherent district leadership style (participative, consultative, autocratic)?

What was your perception of the Chairman/DGM (or DMT) style and competence in handling the closure?

Who took the lead in focusing attention against the closure? Why?

How would you describe his/her/their style and competence in handling the opposition to the closure?

Planning and Evaluation Considerations

Were there any major differences between Regional and District strategies?

What were the main outcomes of the District review meeting which preceded the closure?

Geographical Considerations

Were the neighbouring Districts self-sufficient in maternity services?

Which political party was in control locally?

What was the socio-economic profile of the district?

B The PROCESS (HOW) of Implementation

Antecedent Conditions

What was the history of closure and change of use of health facilities/of maternity services in the District? Was the District familiar with the closure procedure?

Were there any unforeseen precipitating (eg crisis conditions, financial difficulties) factors for closure?

Was the closure of the maternity unit or of the unit ever considered before?

Were there any rumours of closure or change of use at the time of the announcement?

Was any opposition to the proposal expected? Why?

Were there any favourable conditions for closure?

The Decision Making Process

*** Identification**

Where did the idea come from?

Who first brought the situation to general attention?

What was the triggering point (ie the point at which so many indicators have accumulated that the problem can no longer be ignored)?

*** Development**

How was the situation handled?

Who was involved?

Was there much dissent regarding the proposal?

Who were the dissenters?

Were a range of alternative options explored?

How carefully?

Why was closure chosen?

Management of meaning process

a) the action (labelling, sense-making, consensus-building)

- * How was the closure presented to the public?
- * Were there any unthinkable (eg savings, need for space, etc) or ready-made (eg end of lease, closure of the whole hospital, opening of new facilities, etc) justification for the closure?
- * How carefully have the reasons for closure been worked out?
- * Were all the arguments (eg saving, staffing levels, etc) checked out before issuing the consultative document? Why?
- * Was there any concomitant problem (other than maternity) that the closure helped to solve? What was the relationship between these problems?
- * Which labels were used to describe the closure (eg closure, transfer, change of use, rationalisation, development programme, etc) and by whom were they used, and why?

- * Has anything been done in order to make the closure more attractive and to make the decision acceptable? How did you develop support and commitment for the decision?
- * What was the general feeling about the consultation procedure?
- * Was the speed of implementation important? Why?
- * What aids for closure (eg new modern additional facilities, new jobs, transitional assistance, etc) were available to ease the implementation process?

Tactics for Closure

- * Time closure to coincide with change in political/professional support.
- * Precede closure with negative evaluations.
- * Promise to provide a superior alternative.
- * Gain support of Region and DHSS in advance
- * Cushion the blow by reducing (or temporarily closing) service levels in advance.
- * Coincide with period of fiscal stringency.
- * Close the unit quickly.

- * Explain the rationale and emphasise opportunity costs.
- * Close the unit after a shift in public attitudes about it.

b) the reaction

- * Who formed the nucleus of the opposition?
- * What were the main issues at stake and base of power available?
- * Was there any tradition of conflict and militancy in the district?
- * At which step have you been involved in the process?
- * Was it anything in particular which was raising the appeal of the unit?
- * What were the major arguments against the closure of the unit?
- * Did you get any backing from the professionals involved?
- * How did you lobby for support?

Tactics of Survival

- * What did you do (1) to secure support of superiors (DHSS, RHA) and other persons of prestige, and (2) to secure public support?
- * Was a compromise acceptable? Why?

c) the transaction

Was there any formal or informal assessment of the negative impacts of confrontation with the CHC/the GPs/other groups?

What were the key negotiation channels and control mechanisms?

What was the general feeling about going to the Secretary of State for a decision on the matter?

C The CONTENT (WHAT) Implementation

What are the main characteristics of maternity care which could help defining it as a health care issue - for example:

- * Happy event and successful output;
- * Patient's discretion on use of service;
- * The correct format for maternity services could be important and could differ between districts;
- * Rather common, standard, predictable and relatively simple;
- * Universal and almost exclusively NHS;
- * Involved an emergency episode most of the time;
- * It has a rather high emotional appeal and it has 'good press'.

Is maternity sidestep part of the problematic characteristic of health care analysis? Which?

What was the particular place of the maternity unit closure in the realisation of the District strategic and operational plans at the Regional, District and Unit levels?

What are the various interpretations of the guidelines and directives concerning -

- * 'isolated' vs 'integrated' GP maternity Units;
- * closure and change of use of health facilities

Was the local commitment to close clear?

What was the main rationale for closing?

- Economisers: advocate closing non-essential, marginally useful, or obsolete facilities;
- Reformers: advocate the establishment of a better policy.

D The OUTER CONTEXT (WHY) of Closure

What was the impact of the following elements on the implementation of the proposals?

- * the economic climate and the ideological outlook of the government in power;
- * the historical development of maternity/obstetric services;

- * shifts in attitudes, beliefs or ideology about GP maternity service (changes in the ideological and attitudinal dimensions);
- * national public opinion.

Bureaucratic Features (interpretation)

- * DHSS/Region policy concerning maternity and obstetrics;
- * The Closures and Changes of Use of Health Facilities (Circular HSC (IS) 127);
- * The OPCS projections and the norm for provision of maternity beds;
- * National and Regional priorities;
- * RAWP and Regional distribution policy;
- * Policy content and the macro aspect of implementation (influence on local delivery organisations to close 'isolated' GPMU);
- * Development of the planning system and the review process.

Professional Features

- * The RCOG and RCGP positions vs GPMU;
- * National shortage of nurses and midwives and recruiting problems, impact on the District;

E The OUTCOME of Implementation

How successful did the closure proposal turn out to be?

Did it achieve its original objectives without any variation or did the original intentions change?

Were there any unforeseen side-effects to the closure?

Was the speed at which the District moved towards implementation satisfactory?

Would the same decision and implementation procedure be carried out again, given the information now known?

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